CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1940

KP 23907

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. ☐ Establish retention period for records which are accumulating daily.

B. ☐ Dispose of present accumulation, no additional accumulation anticipated.

C. ☐ Microfilm and destroy originals.

D. ☒ Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES ☐ NO ☒

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Fairley M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	☐	☒	☐

REMARKS:

C. P. Powell Records Management Officer 3/29/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

G19556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

G19556

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Edgewood
(If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location) Edgewood
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Pierce

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-27-29

8. AGE: Years	Months	Days	If less than one day: hr.	min.
15	0	6		

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name John Pierce
13. Birthplace Balt. County

MOTHER
14. Maiden Name Louise Weaber
15. Birthplace Balto

16 (a) Informant hosp. records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 4 1944 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran
Location Upper Md

18 (a) Funeral director H K McGowan Son
(b) Address Edgewood Md

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

AUG 3 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1944 to 8-1 1944 and that I last saw him alive on 8-1 19 44

Immediate cause of death atelectasis

Due to pneumonia (bulbar) Staphylococcus aureus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy pulmonary infiltration

Duration
5 d.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret H.D. Smith M. D.

Address Sydenham Hosp Date signed 8-2

G19557

BALTIMORE CITY HEALTH DEPARTMENT X - G19557
Registered No.

CERTIFICATE OF DEATH 119a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Methanicsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME - Laurence Markland

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-13-44

8. AGE: Years	Months	Days	If less than one day
	6	19	hr. min.

9. Birthplace Mechanicsville Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Fred. Markland
13. Birthplace Md.

MOTHER
14. Maiden Name Agnes Countess
15. Birthplace Md

16 (a) Informant Rhonda r.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. J[illegible]
Location Morgan[illegible]

18 (a) Funeral director M[illegible] Sons
(b) Address [illegible]

19 (a) AUG 3 1944 (b) [illegible]
(Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 2 1944 at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 2 1944, to Aug - 2 1944, and that I last saw him alive on Aug - 2 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Acidosis	1 day
Due to Acute nutritional disturbance (diarrhea)	1 week
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp Date signed 8-3-44

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19558

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G19558

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital (inst. (yrs., mos., or days) Same.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Sandy Spring (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Thompson

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	(a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 25-1916

8. AGE: Years	Months	Days	If less than one day
28	5	2	hr. min.

9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation None
11. Industry or business —

FATHER
12. Name John Thompson
13. Birthplace Texas

MOTHER
14. Maiden Name Etta Mills
15. Birthplace Texas

16 (a) Informant Mrs. Etta Cantwell
(b) Address Sandy Spring

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 3 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Carmell
Location Montgomery County

18 (a) Funeral director G W Barbert
(b) Address Sandy Spring

19 (a) AUG 4 (Date rec'd by registrar) (b) Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3 1944 at 5:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-19 1944 to 8-3 1944 and that I last saw h.. alive on 8-3 1944.

Immediate cause of death Respiratory Arrest — Duration

Due to Tuberculosis of spine

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Rinehart M. D.
Address Univ. Hosp. Date signed 8-3-44

G19559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G19559 Registered No.

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill the causes of death clearly and legibly. correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 S. Mason St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Henry Ripperon
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Ripperon
13. Birthplace Md.

MOTHER 14. Maiden Name Frances ? ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-4-1944 (month) (day) (year)
(c) Cemetery or crematory Cemetery
Location Millers Md

18 (a) Funeral director Guy M. Winkler Sons
(b) Address Westminster Md

19 AUG 4 194 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-3 1944, at 7.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-3 1944, to Aug 3 1944, and that I last saw him alive on Aug-3 1944.

Immediate cause of death	Duration
prematurity	12 hrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp Date signed 8-3-44

G19560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G19560

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 15-16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Ford Ave. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hemp

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Raymond Joseph Hemp
13. Birthplace Md

MOTHER
14. Maiden Name Dorothy Swaner
15. Birthplace Maryland

16 (a) Informant Lionel Hemp
(b) Address 12 [illegible] Ludlow Mark
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/44 (month) (day) (year)
(c) Cemetery or crematory St Augustine
Location Elkridge Md.
18 (a) Funeral director [illegible] R Kemp
(b) Address 12 [illegible] Ludlow, Baltimore Md
19 (a) Date received AUG 4 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1944, at 11 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944, to Aug 2 1944, and that I last saw h[illegible] alive on Aug 2 1944.

Immediate cause of death Tetanus Spasm

	Duration
Due to	
Due to	
Other Conditions Spina Bifida	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. McCormack M. D.
Address Maryland General Date signed Aug 3 44

G19561

Jo #88947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

Registered No. G19561

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or institution (yrs., mos., days) 16 days
(e) Length of stay in Baltimore (yrs., mos., days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Block Fairhaven Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil Mei[illegible]

3 (b) If veteran, name war (c) Social Security Account

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 71 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unable to obtain further information.
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month, day, year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 3, 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 4 1944 (Date rec'd by registrar) (Registrar)

VS 150

2063

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1944, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 11, 1944, to July 27, 1944, and that I last saw h[illegible] alive on July 27, 1944.

Immediate cause of death [illegible] — Duration

Due to Undetermined etiology

Due to

Other Conditions Arteriosclerotic Cardiovascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. M. Phillips

Address Balt City Hosp Date signed 8-2-44 (M. D.)

G19562

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. G19562

CERTIFICATE OF DEATH

159

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-2
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County B. C.
(c) City or town Born in Hosp. (If outside city or town limits, write RURAL and give town)
(d) Street No. 5042 Hoffman Rd. (If rural give location)
(e) Citizen of foreign country Germany (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Kastler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace University Hospital, Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Ernest Kastler

13. Birthplace Md.

MOTHER 14. Maiden Name Olive Schmidt

15. Birthplace Md.

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 3 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) Received AUG 4 1944 (b) Signature Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3 1944, at 1-30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 1944, to 8-3 1944, and that I last saw her alive on 8-3 1944.

Immediate cause of death Resp. failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Polvason M. D.

Address University Hospital Date signed 8-3-44

2065

G19563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V G19563 Registered No. 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County Baltimore Md.
(c) City or town University Hospital
(If outside city or town limits, write RURAL and give town)
(d) Street No. Middle Russia
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Girl Staley

3 (b) If veteran, name war — | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	—

6 (b) Name of husband or wife —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-24-44

8. AGE: Years	Months	Days	If less than one day
		5	hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business .....
FATHER 12. Name John H. Staley
13. Birthplace Pennsylvania
MOTHER 14. Maiden Name Emma Lindsay
15. Birthplace N.C.
16 (a) Informant .....
(b) Address .....
17 (a) ..... (b) Date thereof .....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory .....
Location UNIVERSITY MEDICAL SCHOOL AUG 3 1944
18 (a) Funeral director Commissioner of Health
(b) Address .....
AUG 4 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/24 1944, at ..... M
21. I certify that death occurred on the date above stated; that I attended deceased from Interne on the service 19..., and that I last saw h... alive on ..... 19....

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....
23. Signature Edward Palmason M. D.
Address University Hospital Date signed 7-31-44

VS 150

2064

G19564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G19564 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Broadway.
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 205
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 2529 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jean Carlton.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-18-44

8. AGE: Years | Months | Days 15 If less than one day: 2 wks. hr. — min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Johnny Carlton
13. Birthplace Va.

MOTHER 14. Maiden Name Mary E. Stolzenbach.
15. Birthplace Md. Baltimore

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Aug. 4/44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cem.
Location Baltimore Md

18 (a) Funeral director Charles J. Schwab
(b) Address 505 N. Monroe St.

19 (a) AUG 4 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 2 1944 and that I last saw h[illegible] alive on Aug 2 44

Immediate cause of death Renal shutdown — Duration

Due to Dehydration & acidosis

Due to Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp. Date signed 8-3-44

G19565

JO #83710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G19565

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Mo. 22 days

(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 420 Lombard St. W.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Hugh Grigsby

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Sadie (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1872

8. AGE: Years	Months	Days	If less than one day
72	-3-	22	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Richard (d)

13. Birthplace Virginia

MOTHER

14. Maiden Name Mary Queen (d)

15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Aug 5-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory W. W. Laharty

Location W. W. Co

18 (a) Funeral director Lamb & Chase Bros

(b) Address 638 N. Gilmor St

19 (a) AUG 4 - 1944 Huntingtown, Maryland
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1, 1944, at 12:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1943 to 8-1 1944, and that I last saw h[illegible] alive on 8-1 1944

Immediate cause of death	Duration
Pulmonary tuberculosis & hemoptysis	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify yes or no)

(e) Means of injury

23. Signature C. Perry J. M. D.

Address City Hosp. Date signed 8-4-44

C19566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Reg. No. C19566

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. 8
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Roslyn Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY Catherine Muth.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race W

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15 1871

8. AGE: Years 73 | Months 5 | Days 18 | If less than one day 10 hr. 15 min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Home.

11. Industry or business

FATHER 12. Name Mr. M. Joseph Muth.

13. Birthplace Bavaria.

MOTHER 14. Maiden Name Josephine Futtenberger

15. Birthplace Baltimore Md.

16 (a) Informant Miss Margaret Muth

(b) Address 2307 Roslyn Ave.

17 (a) Burial (b) Date thereof 8/7/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore Md.

18 (a) Funeral director H. W. Mears and Son

(b) Address 805 N. Calvert St.

AUG 4 - 1944 Wm. Livingston Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3rd. 1944 at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1943 to Aug. 3, 1944, and that I last saw h[illegible] alive on Aug 3rd 1944.

Immediate cause of death	Duration
Cardio-respiratory failure.	12 hrs.
Due to Arteriosclerosis and Chronic Nephritis	15 yrs.
Due to Carcinoma of Sigmoid	10 mo.
Other Conditions	1 yr.

(Include pregnancy within 3 months of death)

Date of operation Sept 15th. 1943
Feb 13 1944

Major findings of operation: Carcinoma of Sigmoid metastasis.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Z. Berry M. D.

Address Mercy Hospital Date signed 8/3/44

G19567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G19567

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2900 N. Calvert (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Hull

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Deceased

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) 11/21/1866

8. AGE: Years	Months	Days	If less than one day
77	8	11	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Robert M. Wherrett
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Elizabeth Lacy
15. Birthplace Ireland

16 (a) Informant Joanna Lacy Hull
(b) Address 2900 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

AUG 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2 1944, at 8.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/8 1944, to 8/2 1944, and that I last saw h alive on 8/2 1944

Immediate cause of death Respiratory failure — Duration

Due to Cerebral hemorrhage — 24 hrs

Due to Arteriosclerotic — Duration

C.V.D. — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature L. B. Bray

Address Mercy Date signed 8/2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G19568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G19568 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 N. Stricker St
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rena L Crumples

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-18-9965

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife James King Crumples
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/24/1906

8. AGE: Years	Months	Days	If less than one day
39		7	hr. min.

9. Birthplace Teacher N. C.
(Town, county, and State)
10. Usual Occupation Factory (Stitcher)
11. Industry or business

FATHER
12. Name Ernest Murry
13. Birthplace Teachey N C

MOTHER
14. Maiden Name Arthine Wells
15. Birthplace Teachey N. C.

16 (a) Informant James King Crumples
(b) Address 704 Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Wallace, N. C.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) AUG 4 1944 (Date received by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/1 1944 at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1944 to 8/1 1944 and that I last saw her alive on 7/31 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to	
Due to Hypertensive	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams
Address 1131 Harlem Ave (Date signed) 8/1/44 M D

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

L - 649569 / 122 B

Registered No. G19569

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 Dorn St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18, 1897

8. AGE: Years 47 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Truck Driver

11. Industry or business

FATHER
12. Name Franklin
13. Birthplace Va.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-44 (month) (day) (year)
(c) Cemetery or crematory
Location Washington, D. C.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 AUG 4 - 1944 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1944, at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-44 19 to 8-2-44 19, and that I last saw him alive on 8-2-44. 19

	Duration
Immediate cause of death Atelectasis	3 hours
Due to Toxemia Post operative Shock	
Due to Intestinal Obstruction	3 days
Due to Adhesions	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Above 8-2-44
Major findings of operation: Above
of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto. City Hosp. Date signed 8-3-44

G19570

G19570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 835 ½ W. Franklin Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 W. Franklin Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Bradford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Richmond Va.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Robert Bradford
13. Birthplace Va.

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Va.

16 (a) Informant Mrs. Frank Bradford
(b) Address 1102 Myrtle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6 '44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Baltimore Md.

18 (a) Funeral director Jesse W. Riddell
(b) Address 423 W. Biddle St.
Huntington Williams Registrar

19 (a) (Date received by registrar) AUG 4 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1944 at 8 30 P. M

21. I certify that I took charge of the remains described above, held an On Query Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Preston M.D.
Medical Examiner.
Date signed August 3 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G19571

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G19571 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison Lanvale Sts
(c) Hospital or institution: Maryland Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 40 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N Bruce St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph C. Lee

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Birtie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-31-83

8. AGE: Years 60 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER 12. Name Joseph Lee
13. Birthplace Balto, Md.

MOTHER 14. Maiden Name Katherine Key
15. Birthplace Penna.

16 (a) Informant Mrs Bertie V. Lee
(b) Address 506 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)

(c) Cemetery or crematory Balto U S Nat Cem
Location Frederick Ave

18 (a) Funeral director William M Mareck
(b) Address 715 Light St

19 (a) 8/4/44 (Date rec'd by registrar) (b) Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1944, at 11¾ P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-22 1944, to 8-1 1944, and that I last saw him alive on 8-1 1944.

Immediate cause of death Pneumonia (Lobar) — Duration 10 days

Due to Debility

Due to Prostate Adenoma

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo B Gallagher M. D.
Address Maryland Genl Hosp Date signed 8-7-44

G19572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19572

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 W Saratoga St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(d) State Md (b) County —
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 821 W. Saratoga St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Elizabeth Thompson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Fem.
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John W Thompson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 14 1889

8. AGE: Years 57 Months 0 Days 17 If less than one day hr. — min.

9. Birthplace Spanns Point Md (Town, county, and State)

10. Usual Occupation Domestic
11. Industry or business Household

FATHER
12. Name Geo. W. Scott
13. Birthplace New Guinea Maryland

MOTHER
14. Maiden Name Margaret Gray
15. Birthplace Oakhornaby Md

16 (a) Informant Undertaker
(b) Address 321 N Schroeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5 1937 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location —

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date received) AUG 4 1937 Huntington (b) Signature —

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1937 at 4:32 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1937 to 8-1 1937 and that I last saw h. alive on 8-1 1937

Immediate cause of death: Hypertensive Cardiac Disease — Duration 1 yr.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature C. M. Fifer M.D.
Address 5360 Larvale Ave Date signed 8-3-37

PHYSICIAN
Underline the cause to which death should be charged statistically.

G19573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G19573 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1000 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Henry Walker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 8, 1901

8. AGE: Years 42 | Months 9 | Days 0 | If less than one day — hr. — min.

9. Birthplace Columbia S.C.
(Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name Alex Jackson
13. Birthplace Winnsboro, S.C.

MOTHER
14. Maiden Name Ida Hughey
15. Birthplace Winnsboro S.C.

16 (a) Informant Henry Walker
(b) Address 1500 W Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5 1944 (month) (day) (year)

(c) Cemetery or crematory Winnsboro
Location S.C.

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 S Schroeder St

19 (a) AUG 4 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2/1944, at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6 1944 to 8/2 1944, and that I last saw her alive on 8/2 1944.

Immediate cause of death: Hemorrhage Peritonitis — Duration

Due to: Generalized Peritonitis

Due to: Pelvic Abscess

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-8-44

Major findings of operation: Old degenerating tubo ovarian abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Jackson M.D.

Address Provident Hosp. Date signed 8/3/44

Huntington Williams, M.D.

G19574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19574 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 508 Parrish
(b) Street address ~~[illegible]~~
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
Street No. 508 Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Plummer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife Frank Plummer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4 86

8. AGE: Years 90 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Raleigh, N C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Unk

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Carol Smith
(b) Address 508 N Carrol St

17 (a) Burial (b) Date thereof Aug 5 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 3221 Schroeder St

19 (a) (Date received by registrar) AUG 4 - 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 830

20. DATE OF DEATH July 1 1944, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1940 to July 1 1944, and that I last saw h[illegible] alive on July 31 1944

Immediate cause of death: Hypertensive Cardio Renal Vascular — Duration: 4/years
Due to Senility
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Nature of injury
23. Signature H. R. Waters M. D.
Address 1228 Pa Ave Date signed July 31 1944

Approved Medical Examiner

G19575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2121 Hanover Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Bergen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1889

8. AGE: Years	Months	Days	If less than one day
54 53	10	22	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Richard Bergen
13. Birthplace N. Y.

MOTHER
14. Maiden Name Unknown
15. Birthplace ?

16 (a) Informant Anne Hornberger
(b) Address 1703 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Rd.

18 (a) Funeral director Roy J. Kenny
(b) Address Hollins & Fulton Sts.

19 (a) AUG 4 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1944, at 2 40 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham, M.D. Medical Examiner.
Date signed August 3 1944

G19576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G19576

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 125 Warren Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Warren Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Josephine Ritter

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife Luther Ritter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1861

8. AGE: Years 82 | Months 9 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Corbitt
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Moran
15. Birthplace Ireland

16 (a) Informant Mrs. Francis Hughes
(b) Address 125 Warren Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 4/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Fred. A. Krause & Son
(b) Address 1216 E. Chase St.

19 (Date received by registrar) AUG 4 - 1944 Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 1 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Aug. 1 1944 and that I last saw h.e.r. alive on Aug. 1 1944

Immediate cause of death: Myocardial Insufficiency — Duration 2wks.
Due to Chronic Myocarditis — 4yrs.
Due to Senility
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John V. Zyerbicki
Address 1802 Eastern Date signed 8-3-44 (M. D.)

G19577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Dist 83a

G19577 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days) 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5115 Ardmore Way (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Howard (HARRY) J. HARRIS

3 (b) If veteran, name war. | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rose Harris

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 16-1888

8. AGE: Years 56 | Months | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Brewery Worker

11. Industry or business

FATHER 12. Name Charles Harris
13. Birthplace North Carolina

MOTHER 14. Maiden Name Mary Anne Hammil
15. Birthplace North Carolina

16 (a) Informant Rex Harris
(b) Address 5115 Ardmore Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kaminskas Sons
(b) Address 60 E Washington St

19 AUG 4 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2, 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from August 2, 1944 to August 2 44 and that I last saw h[im] alive on August 2, 1944

Immediate cause of death: Cardio Respiratory Failure — Duration

Due to: Cerebrovascular Accident — 10 hours

Due to: Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R Davis M. D.
Address Mercy Date signed 8-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 3

Registered No. G19578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address D.O.A. Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apts.
(If rural give location)
Eutaw Place + Brookfield Ave
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM CAHN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mollie W. Cahn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 5, 1866.

8. AGE: Years	Months	Days	If less than one day
78	3 2	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired.

11. Industry or business

FATHER
12. Name Felix Cahn,
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown,
15. Birthplace Germany.

16 (a) Informant Mr. Stanley Cahn,
(b) Address 36 S. Paca St.

17 (a) Burial (b) Date thereof 8/6/44.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Baird Sonneborn & Son
(b) Address 1902 Eutaw Place.

19 (Signature of registrar) AUG 4 - 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4th, 1944, at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to 19..., and that I last saw him alive on Aug 4 1944.

Immediate cause of death
Due to Hemorrhage from Urinary Bladder + Shock — Duration: 2 hrs
Due to Benign enlargement of Prostate — 8 yrs.
Due to Carcinoma of prostate and bladder — ?

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benj D. Ahrens M.D.
Address 100 W. Monument St Date signed 8/4/44

G19579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G19579 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perfecto Martinez, Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 192[illegible]

8. AGE: Years	Months	Days	If less than one day
19	3	20	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Naval

11. Industry or business Helper in kitchen

FATHER
12. Name Perfecto Martinez
13. Birthplace Porto Rico

MOTHER
14. Maiden Name Estella Pack
15. Birthplace Balto. Md.

16 (a) Informant Estella Martinez
(b) Address 816 Greenmount Avenue

17 (a) Burial (b) Date thereof Aug. 4th 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Belmont Thomas & Harris
(b) Address 721 Cathedral St.

AUG 4 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH July 31, 1944, at 5:40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5:30 P. at July 31, 1944 M.
(b) Where did injury occur? Jones Falls - North and 29th St. Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed August 4, 1944

13/5

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G19580

BALTIMORE CITY HEALTH DEPARTMENT ✓ G19580
CERTIFICATE OF DEATH 30a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3524 Gwynn Mount
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3524 Gwynn Mount (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. John Robert Abercrombie

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Emma S. Abercrombie
6 (c) If alive, give age 72 years
7. Birth date of deceased (mo., day, yr.) Feb-21-1869

8. AGE: Years 75 | Months 5 | Days 13 1/2 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Physician
11. Industry or business Medicine

MOTHER / FATHER
12. Name John Abercrombie
13. Birthplace Scotland
14. Maiden Name Elizabeth Daniels
15. Birthplace Canada

16 (a) Informant Mrs. E. S. Abercrombie (wife)
(b) Address 3524 Gwynn Mount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-7-44 (month) (day) (year)
(c) Cemetery or crematory Gwynn Mount
Location Baltimore

18 (a) Funeral director Stewart & Mowen Co.
(b) Address 1810 North Ave.

19 (a) Filed AUG 4 1944 (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.K.

20. DATE OF DEATH August 3 1944, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1920 19 to 1944 19, and that I last saw him alive on about July 30, 1944

Immediate cause of death: Coronary Thrombosis — Duration: About 15 min

Due to: Occlusion of coronary artery

Due to: arteriosclerosis and syphilis

Other Conditions: Tabes dorsalis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John J. Sloan M. D.
Address 928 N. Charles Date signed 8/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19581 Registered No. 115 744

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or Institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909. Foster Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Rainer

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.:

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: MARIE T. RAINER

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): AUG. 10 1882

8. AGE: Years 61 | Months 11 | Days 16 | If less than one day: 24 hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: WAX MIXER

11. Industry or business: CROWN CORK & SEAL

FATHER
12. Name: JOSEPH D. RAINER
13. Birthplace: BALTO. MD.

MOTHER
14. Maiden Name: MARTHA WIMSITT
15. Birthplace: BALTO. MD.

16 (a) Informant: MARIE T. RAINER (WIFE)
(b) Address: 3909 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: AUG. 8/44 (month) (day) (year)
(c) Cemetery or crematory: SACRED HEART
Location: GERMAN HILL ROAD

18 (a) Funeral director: Lilly and Zeiler INC
(b) Address: 403 S. WOLFE ST.

19 (a) AUG 4 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4/44 19 . at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19 1944 to 8/4/44 19 , and that I last saw h[illegible] alive on 8/4/44 19

Immediate cause of death: Heart Failure — Duration

Due to: Myocardial insufficiency

Due to: Coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Williams J. Byrnes M.D.

Address: St. Agnes Hospital Date signed 8/4/44

G19582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G19582

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully noted. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1742 Orleans Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1927

8. AGE: Years	Months	Days	If less than one day
17	3	25	hr. min.

9. Birthplace Wake Forest, N.C.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Cyphus Mitchell
13. Birthplace N.C.

MOTHER
14. Maiden Name Lillie Hall
15. Birthplace N.C.

16 (a) Informant Lillie Mitchell
(b) Address 1742 Orleans St

17 (a) Burial (b) Date thereof 8/5/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Wake Forest, N.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

8-4-1944
(Date rec'd by registrar) Acting for Williams M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1944, at 25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of abdomen.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-3-44 at 4:15 P.M.
(b) Where did injury occur? 1751 Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury shot without provocation

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.

Date signed 8-4-44

G19583

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G19583
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 East Baltimore Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME
Harry Anthony Schrenker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 23 1944
8. AGE: Years | Months | Days: 4 | If less than one day: hr. min.
9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name: Benjamin Schrenker
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Florence Boblitz
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address: Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL AUG 4 1944

18 (a) Funeral director: Commissioner of Health
(b) Address

19 AUG 4 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27, 1944, at 7:56 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 23 1944, to July 27, 1944, and that I last saw him alive on July 27 1944.

Immediate cause of death: Prematurity

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Philip P. Stephens, Jr. M. D.
Address Johns Hopkins Hospital Date signed 7-28-44

2069

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19584 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3110 Savoy Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Savoy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L Perrish

3 (b) If veteran, name war
3 (c) Social Security Account No. 215-05-8789

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Ida B. Frazer
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1876

8. AGE: Years	Months	Days	If less than one day
67	9	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Standard Oil Co

FATHER
12. Name Henry Clay Perrish
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Ann Matheus
15. Birthplace Baltimore

16 (a) Informant Mrs. Ida Perrish
(b) Address 3110 Savoy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D.

AUG 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1944 at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Aug 2 1944, and that I last saw him alive on Aug 2 1944

Immediate cause of death Cerebral Thrombosis — Duration 2 Hours
Due to arteriosclerosis
Due to
Other Conditions Bilateral Hemiplegia — 2 Hrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller
Address 1228 S Charles St Date signed 8/4/44

Dr. Miller 1228 S. Charles St

G19585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G19585 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 S. Highland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Highland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Werth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Conrad Werth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22 - 1874

8. AGE: Years	Months	Days	If less than one day
72	5	11/10	hr. min.

9. Birthplace Germany (Town, County, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Mentzel
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Margaret Menne
(b) Address 318 S. Highland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6-44 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem.
Location Donnell St.

18 (a) Funeral director John A. Meffan
(b) Address 2334 Jefferson St.

19 (Date rec'd by registrar) AUG 5 - 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1944 at 3:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 21 1944, to Aug 2 1944, and that I last saw h alive on Aug 1 1944.

Immediate cause of death Arteriosclerotic
C. V. Disease.
Emphysema and Failure

	Duration
Due to	7-21-44
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Schmunk M. D.
Address 842 S. Eden Date signed 8-9-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

53

Registered No. G19586

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 da
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 110 West University Parkway Carolina Apts (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Jos. Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife William T.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1870

8. AGE: Years 73 | Months 7 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Andrew J. Ryan
13. Birthplace Md (Westminster)

MOTHER
14. Maiden Name Matilda Hunt
15. Birthplace Md (Balto.)

16 (a) Informant Mr. Chas. B. Hobbs
(b) Address Gladestone Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day), (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto. Md.

18 (a) Funeral director Wm. J. Tideman
(b) Address Balto. Md.

19 AUG 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1944, at 5:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 1944 to Aug 4 1944, and that I last saw her alive on Aug 4 1944.

Immediate cause of death	Duration
Carcinoma of face	10 mos.
Due to.....	
Due to.....	
Other Conditions.....	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....

23. Signature Glenn P. Grove
Address Union Memorial Hosp. Date signed 8/4/44 M. D.

(OVER)

G19587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G19587

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5916 Smith Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5916 Smith Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPHINE RYAN

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1863

8. AGE: Years	Months	Days	If less than one day
80	7	12	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Ryan
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridgett Powell
15. Birthplace Ireland

16 (a) Informant Mrs. Mary Kelly
(b) Address 5916 Smith Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's Cem.
Location Govans, Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 1944, at 9:05 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to Aug 2 1944, and that I last saw h[illegible] alive on Aug 1 19[illegible].

Immediate cause of death Myocardial Failure
Due to Arteriosclerotic C.V.D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 4032 Falls Rd. Date signed 8/5/44

G19588 Incomplete informant? BALTIMORE CITY HEALTH DEPARTMENT ✓ G19588

CERTIFICATE OF DEATH 83a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 W. Rogers Ave.
(c) Hospital or institution:
Methodist Home for Aged 15 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) --

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE J. REVER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John H. G. Rever
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1867

8. AGE: Years 77 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Charles Swearer
13. Birthplace Balto.

MOTHER 14. Maiden Name Cornelia C. Tomlinson
15. Birthplace Balto.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 1944, at 10:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944, to Aug 2 1944, and that I last saw h[illegible] alive on Aug 2 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 3 days
Due to Arteriosclerosis — 10 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Arthur J Danes. M. D.
Address 800 N 3 St Date signed 7-4-45

G19589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G19589 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Sarasota (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY E. FOX

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife John Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1873

8. AGE: Years	Months	Days	If less than one day
71	3	28	hr. min.

9. Birthplace Trenton, N. J. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wesley Owens
13. Birthplace Trenton, N. J.

MOTHER
14. Maiden Name Mary [illegible]
15. Birthplace Trenton, N. J.

16 (a) Informant Mr. Charles O. Tydings
(b) Address 4119 Roland Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/5/44 (month) (day) (year)
(c) Cemetery or crematory Greenwood Cem.,
Location Trenton, N. J.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 5 - 1944 (Date rec'd by Registrar) [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4, 1944, at 2:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944, to Aug. 3 1944, and that I last saw h.e alive on Aug. 2 1944.

Immediate cause of death Pulmonary Edema — Duration few days
Due to Arteriosclerotic Cardio-Vascular Disease — Duration several years
Due to
Other Conditions Cancer of Large Intestine
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 610 N. 3rd St Date signed 8-4-44

G19590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19590

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 Beaufort Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-1/8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Beaufort Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mabel W. Lee or Lilabel W. Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married, widowed, or~~ divorced: Divorced

6 (b) Name of husband ~~or wife~~: M. D. Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1879

8. AGE: Years 65 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Private

MOTHER / FATHER

12. Name James Hamilton Ward

13. Birthplace Frostburg Md.

14. Maiden Name Alice Dilley

15. Birthplace Md.

16 (a) Informant Geo. N. Ward

(b) Address 1903 Hammonds Ferry Rd

17 (a) Removal (b) Date thereof 8/5/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cumberland
Location Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

AUG 5 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3rd 1944, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 26 1943 to Aug. 3 1944, and that I last saw her alive on Aug. 2 1944.

Immediate cause of death	Duration
1) Cerebro-Vascular Renal Disease	1 yr.
Due to	
Due to	
Other Conditions - Secondary Anemia. (Include pregnancy within 3 months of death)	1 yr.

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers

Address 4108 Liberty Hts Date signed M. 8 D. 4/44

G19591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19591 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1417 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 N. Gay St (Or rural-route location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel B. Wentz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1882

8. AGE: Years	Months	Days	If less than one day
62		2	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. J. Leech

FATHER 13. Birthplace Leonardstown Md.

MOTHER 14. Maiden Name Eliz. England

MOTHER 15. Birthplace Baltimore Md.

16 (a) Informant Fannie Morrison

(b) Address 1417 N. Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cemetery

Location Eastern ave

18 (a) Funeral director Howard N. Blight Jr

(b) Address 4914 Belair Road

19 AUG 5 - 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 3, 1944, at 12.30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from APRIL 29 1944, to AUGUST 3 1944, and that I last saw her alive on AUGUST 2 1944

Immediate cause of death: Chronic Myocarditis — Duration: 5 yrs

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor Goldberg M.D.

Address 3100 Harford Road Date signed 8/3/44

G19592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V.46 D

G19592 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Goodwood Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-3
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Goodwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GARDNER

3 (b) If veteran, name war: World War 1
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alice Franklin Gardner
6 (c) If alive, give age 47 years
7. Birth date of deceased (mo., day, yr.) June 23, 1870
8. AGE: Years 74 | Months 1 | Days 8 7 | If less than one day: hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Ret. Army Officer
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs. Alice Franklin Gardner
(b) Address 2903 Goodwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

AUG 5 - 1944

MEDICAL CERTIFICATION P. M

20. DATE OF DEATH Aug. 3 1944, at 8.47 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to 8/3 1944. I last saw h alive on 8/3 1944

Immediate cause of death Carcinoma of Rectum — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stylus W. Talley M. D.
Address 503 Hanford Rd Date signed 8/7/44

G19593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

Registered No. G19593

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1501 WILLIAM ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 WILLIAM ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA A THUMAN

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEM.	WHITE	WIDOW

6 (b) Name of husband or wife JOE THUMAN
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG 26-1882

8. AGE: Years	Months	Days	If less than one day
61	11	9	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name JOHN C. OSTERHAUS
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARGT PFISTER.
15. Birthplace BALTO MD.

16 (a) Informant KATHERINE NEHMSMANN
(b) Address 1501 WILLIAM ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 7-44 (month) (day) (year)
(c) Cemetery or crematory HOLY CROSS
Location H.A.Co

18 (a) Funeral director Bernard C. Harlow
(b) Address 121 E. West St Hunting Town Williams, M.D. Registrar

AUG 5 - 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 3rd 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to Aug 3 1944, and that I last saw her alive on Aug 3 1944

Immediate cause of death	Duration
— Chronic Endocarditis	2 mos
Due to	
Due to	
Other Conditions General Anasarca	2 mos

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 1279 Williams St Date signed 8/7/44 M. D.

G19594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G19594

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 6
(c) City or town Balto # 11
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3448 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irvin P. Shearer (Shearer

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-10-5817

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs. Mary Shearer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/20/1888

8. AGE: Years 56 | Months 5 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business B&O West. Md. R.R.

FATHER 12. Name Emanuel C Shearer

13. Birthplace Md

MOTHER 14. Maiden Name Mary Utz

15. Birthplace Md.

16 (a) Informant Mary E. Shearer.

(b) Address 3448 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5, 1944 (month) (day) (year)

(c) Cemetery or crematory St Peters

Location Balto Co.

18 (a) Funeral director Lehmann & Donovan

(b) Address 3615 Lehmann Ave.

19 (a) AUG 5 - 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/2/44 19 ... at 9.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31 19 44 to 8/2 19 44 and that I last saw h... alive on 8/2 19 44

Immediate cause of death Card. Failure

Due to Aortic Stenosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. N. Crosby

Address Mercy Hosp Date signed 8/2/44

G19595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Register No. G19595

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3133 Hanwick Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3133 Hanwick Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugh R. Norris.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife: Hallie V. Norris

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan 25, 1885

8. AGE: Years 59 | Months 6 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business Pa. R. R.

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hallie V. Norris.
(b) Address 3133 Hanwick Rd.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Aug 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive.
Location Frederick Md.

18 (a) Funeral director Shoemaker & Donovan.
(b) Address 36 E. 25-27 Chestnut Ave.

Aug 5 1944 Huntington Williams M.D. Registrar
(Date rec'd by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3, 1944, at 4 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to Aug 3 1944, and that I last saw him alive on Aug 2 19 44

Immediate cause of death: Myocardial Insufficiency — Duration: 1 week

Due to: Adenocarcinoma — Duration: 2

Due to: Sigmoid with metastases.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation July 44

Major findings of operation: Obstructing adenocarcinoma of sigmoid.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature W H Smith M. D.

Address 3429 Chas Date signed 4-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19596 Registered No. 124 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2232 W. Baltimore St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 W. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME WILLIAM LLOYD GODMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-01-7747

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Minnie G. Schultz

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) April 16, 1895

8. AGE: Years	Months	Days	If less than one day
49	8	14	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Steel Engineer

11. Industry or business Acme Steel & Eng. Co.

MOTHER / FATHER

12. Name Wm. F. Godman

13. Birthplace Baltimore, Md.

14. Maiden Name Daisy McCoy

15. Birthplace Pennsylvania

16 (a) Informant Minnie G. Schultz Godman

(b) Address 2232 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 7/5/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Pk.

Location Fred. Rd. Irvington

18 (a) Funeral director F. B. Wippert & Son

(b) Address 1850 W. Baltimore St.

19 (a) Filed AUG 5 1944 (b) Registrar (Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5/24/ 1944 to 8/1/ 1944, and that I last saw him alive on 8/1/44 19 .

Immediate cause of death: Cirrhosis of the liver — Duration 2 yr. 8 mos.

Due to —

Due to —

Other Conditions Broncho-pneumonia (hypostatic) — 3 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Deibel M.D.

Address 1226 Hanover St. Date signed 8/4/ 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19597

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19597 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 Fourth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) —
If yes, name country

3 (a) FULL NAME Charles G. Bevans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/1/44

8. AGE: Years | Months 1 | Days 5 weeks 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Sabastian H. Bevans

13. Birthplace Md

MOTHER 14. Maiden Name Helen E. Eriquez

15. Birthplace Md

16 (a) Informant Sabastian H. Bevans

(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5-44 (month) (day) (year)

(c) Cemetery or crematory Glen Mount

Location Baltimore, Md

18 (a) Funeral director F. J. Haywood Son

(b) Address 501 Eastern Ave

AUG 5 - 1944 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1944 at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944 to Aug 4 1944 and that I last saw him alive on 7/4/44

Immediate cause of death Malformation of heart cardiac failure — Duration 12 hours

Due to congenital heart disease — Duration 5 wks.

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Leonard Joel Koenig M. D.

Address Johns Hopkins Hosp Date signed Aug 4-44

G19598

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

131a

G19598

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor Cyg + Dukeland Sts
(c) If hospital or institution West Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 2423 Christian Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H Finneran

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Lina M. Finneran
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 27 1883

8. AGE: Years 61 | Months 3 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Produce business

11. Industry or business —

FATHER 12. Name William H Finneran
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Frances Stewart
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Lina M. Finneran
(b) Address 2423 Christian Street

17 (a) burial (b) Date thereof 8/7/44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Rd

18 (a) Funeral director John J Conway Son
(b) Address 901-03 Wallace Street.

19 (a) Date rec'd by local reg. AUG 5 - 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 1944 to Aug 3 1944 and that I last saw h[illegible] alive on August 3rd 1944

Immediate cause of death Uremia — Duration

Due to Hypertensive Cardio-Vascular Renal Disease 6 days

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:

Some + Anemia of aorta
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving Taylor M. D.
Address U. B. C. H. Date signed 8/3/44

G19599 G19599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3906 Yolanda Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 3906 Yolando Rd (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Jacob Molser

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Katherine Molser
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) 10-20-1859

8. AGE: Years	Months	Days	If less than one day
84	9	14	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Jacob Molser
13. Birthplace Germany.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Raymond Bringer
(b) Address 3906 Yolando Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 7 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Avenue.

18 (a) Funeral director Frederick D. Muller Inc.
(b) Address 3919 E. Monument St.

19 (a) AUG 5 1944 (Filed or registered) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 Aug 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to 3 Aug. 1944, and that I last saw h[illegible] alive on 3 Aug. 1944.

Immediate cause of death Coronary Thrombosis — Duration 9 wks.
Due to High Blood Pres. — 10 yrs.
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Z. Grace Hooper M.D.
Address 3534 Ellerslie Ave Date signed 4 Aug 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

An Entertainment - 1901 Eutaw St.

G19600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G19600

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 532 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Monroe St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rosa May Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Wm Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19th 1875

8. AGE: Years	Months	Days	If less than one day
69	2	16	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Jacob F. Clough
13. Birthplace Hampstead, Md.

MOTHER
14. Maiden Name Nancy Harris
15. Birthplace Hampstead, Md.

16 (a) Informant Robt. M. Lee
(b) Address 2929 - Kissimmee - Parkville-14, Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8 | 7 | 44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wm. Weber & Son
(b) Address 2503 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 5 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4th 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Aug 4 1944
and that I last saw her alive on Aug 4 1944

Immediate cause of death Apoplexy — Duration 1 day

Due to Chr. Cardio-Vascular - Renal disease — 5 yrs

Due to

Other Conditions i

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. J. Lemmon Ramsay, M.D.
Address 1901 Eutaw Pl Date signed 8/5/44

G19601 BALTIMORE CITY HEALTH DEPARTMENT G19601

CERTIFICATE OF DEATH 1318 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 Lauretta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ####
(c) ~~City~~ or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 Lauretta Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John J.Rice

3 (b) If veteran, name war ----
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: Wht.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth C.Rice
6 (c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr.) July 9, 1882
8. AGE: Years 62 | Months - | Days 26 | If less than one day ..... hr. ..... min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Cigar Maker

FATHER
12. Name Martin Rice
13. Birthplace Penna.

MOTHER
14. Maiden Name Mary Hughes
15. Birthplace Phila. Penna.

16 (a) Informant Mrs.Elizabeth C.Rice
(b) Address 2705 Lauretta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug.7,1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Geo. W.Little
(b) Address 2700 Edmondson Ave.

19 (a) ..... (Date rec'd by registrar) (b) Huntington Indiana

VR AUG 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug.4,1944 19.... at 3A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1943 to Aug 4 1944 and that I last saw him alive on Aug 4 1944

Immediate cause of death: Mitral insufficiency — Duration: 1943

Due to: Chronic Nephritis — 1943

Other Conditions: .....

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature John D Bubert M. D.
Address 1802 Park Heights Av Date signed Aug 11/44

G19602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

G19602 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 504 McCabe Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 McCabe Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Juliet May McKnew
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Charles Wm McKnew
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 28th 1867
8. AGE: Years 77 Months 2 Days 5 If less than one day hr. min.
9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name William B. Hale
13. Birthplace Va.

MOTHER
14. Maiden Name Eleanor V. Snyder
15. Birthplace Va

16 (a) Informant W. W. McKnew Balto 18
(b) Address 1648 Kingsway Square
17 (a) Burial (b) Date thereof 8/5/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Trinity Church
Location Long Green Md
18 (a) Funeral director William Bok Inc
(b) Address 1217 St. Paul St
19 (a) (b) Thurlington Williams M.D.

AUG 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1944 at 7:30 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 18 1944 Aug. 3 1944 and that I last saw h.e.r alive on Aug. 2 1944.
Immediate cause of death Carcinoma Rectum — Duration 6 months
Due to Metastases & Liver
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Earl H Benson MD M. D.
Address 511 York Rd Date signed Aug 4, 1944

G19603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19603 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hosp 2715

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4664 Falls Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah Fry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years	Months	Days	If less than one day
18	—	—	— hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Lamech Frey
13. Birthplace Sykesville Md

MOTHER
14. Maiden Name Viola Thomas
15. Birthplace Baltimore

16 (a) Informant Viola Frey
(b) Address 4664 Falls Road

17 (a) Burial (b) Date thereof Aug 7-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory White Rock Cemetery
Location Sykesville Md

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St.

19 (a) Filed Aug 8 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1944, at 11 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Subarachnoid
Hemorrhage of Brain
due to Acute Pulmonary Edema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Gretzer M.D.
Medical Examiner
Date signed August 9 1944

G19604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19604
Registered No.

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1903 E. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cornelius Burley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Burley
13. Birthplace Va.

MOTHER
14. Maiden Name Bell ?
15. Birthplace Va.

16 (a) Informant Willie Burley
(b) Address 1903 E Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location G. A. County Md.

18 (a) Funeral director Mrs. Robert A. Ellis, Dft.
(b) Address 1129 N. Caroline St.

AUG 5 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1944, at 5:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1 1944 to 8-3 1944 and that I last saw h[illegible] alive on 8-3 1944.

Immediate cause of death: Hypostatis and Pulmonary Edema

Due to: Hepatitis and Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Between Onset and Death

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. R. Blake M. D.
Address 1327 N. Central Ave. Date signed 8/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 Rossiter Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 5½ Years

27-11

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Rossiter Avenue (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Edwin M. Barrett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Kathryn Hardwicke
6 (c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1868

8. AGE: Years	Months	Days	If less than one day
75	9	25	-- hr. --- min.

9. Birthplace Cleveland, Ohio (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Wholesale Mfg. Rubber

FATHER
12. Name John Barrett
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary Bliehall
15. Birthplace Ohio

16 (a) Informant Mrs. Edwin M. Barrett
(b) Address 309 Rossiter Avenue

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Wears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd) AUG 5 1944 (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4-44 19, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 3 19 44, to Aug 4 19 44, and that I last saw him alive on 8-4 19 44

Immediate cause of death: Hypertensive Cardio vascular disease

Due to: Cerebral Hemmorhage.

Duration
5 YRS.
5 yrs.

Other Conditions: Diabetes Mellitus 5 YRS.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Henry Fearson. M.D.
Address 5217 York Rd Date signed 8/5/44

G19606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G19606

4706 Harford Rd

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5310 Hamlet Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5310 Hamlet Ave (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country Social Security 215-10-9456

3 (a) FULL NAME Anthony Olszewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9456

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12-1871

8. AGE: Years	Months	Days	If less than one day
73	3	21	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Mary Olszewski
(b) Address 5310 Hamlet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J. Ruck
(b) Address 6305 Harford Rd

19 AUG 5 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1943, to Aug 3 1944, and that I last saw h[illegible] alive on Aug 3 1944

Immediate cause of death: Carcinoma of Stomach with metastasis — Duration: 1½ yrs. [illegible]

Due to

Due to

Other Conditions Anemia (Secondary) Chronic myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harrold MD M
Address 4706 Harford Road Date signed 8/4/44

G19607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19607

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or Town Parkville Farm on Hospital
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7804 Clarkesworth Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Winters

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If [illegible] years

7. Birth date of deceased (mo., day, yr.) August 4 1944

8. AGE: Years | Months | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name R. A. Winters
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Naomi Forest
15. Birthplace Balto. Md

16 (a) Informant R. A. Winters
(b) Address 7804 Clarkesworth Rd

17 (a) Burial (b) Date thereof 8-5-44
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville

18 (a) Funeral director Geo. H. Kemp
(b) Address 1-11 N. Eutaw St

19 (Signature of local registrar) AUG 5 - 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4 1944, at 7:32 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on 8-4 1944.

Immediate cause of death Resp. Failure — Duration

Due to Intracranial Hemorrhage & Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Palmason M. D.
Address Univ. Hospital Date signed 8-5-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G19608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G19608

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 Rutland Ave
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L. Healy

3 (b) If veteran, name war: -
3 (c) Social Security Account No.: -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1937

8. AGE: Years	Months	Days	If less than one day
7	0	25	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name John L. Healy
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Eleanora M. Walter
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. E. J. Billingsley Aunt
(b) Address 1816 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Calvert Cemetery
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Signature and address of registrar) Huntington Williams, M.D.

AUG 5 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4th, 1944, at 9a M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Aug 4 1944, and that I last saw him alive on Aug 3 1944.

Immediate cause of death Bronchopneumonia. — Duration 3 weeks.
Due to — Duration 1 week.
Due to — Duration -
Other conditions Anesthesia Ether. (Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert L. Sidensky M.D.
Address 2939 Dr. Gilbert St. Date signed 8/4/44

Transportation

G19609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G19609 ✓ Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Regan Ave. & Parkland St.

(c) Hospital or institution: West Balto. Gen. Hosp. 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore Md

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3620 Springdale Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Linda Layne Lacy (LACY) ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 28-44

8. AGE: Years | Months | Days: 8 | If less than one day: hr. min.

9. Birthplace Baltimore Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Harry Sowell Lacy

13. Birthplace Akron Ohio

MOTHER

14. Maiden Name Lucille Kitchen

15. Birthplace Bowling Green Kentucky

16 (a) Informant Harry S. LACY

(b) Address 3620 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7 44 (month) (day) (year)

(c) Cemetery or crematory Lacy Burial Ground

Location Bowling Green Kentucky

18 (a) Funeral director Ellsworth Armagost

(b) Address 3914 Liberty Heights Ave

19 AUG 5 - 1944 (b) Huntington Williams M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 19 44 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 19 44 to 8/5 19 44 and that I last saw h[illegible] alive on 8/5 19 44

Immediate cause of death Bronchopneumonia — Duration 2 days

Due to Toxemia (Congen. Hemolytic ?) — Duration 2 days

Due to

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Irving J. Taylor M.D.

Address W. B. G/H. Date signed 8/5/44

Nov 1944 G19610

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. G19610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND County
(b) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Hickory Ave. (If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Chambers
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-05-0887

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	White	MARRIED

6 (b) Name of husband or wife MRS. MARY E. CHAMBERS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8-1883

8. AGE: Years	Months	Days	If less than one day
61	4	27	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation UNEMPLOYED
11. Industry or business

FATHER
12. Name Joseph Chambers
13. Birthplace Penna.

MOTHER
14. Maiden Name [illegible]
15. Birthplace Penna.

16 (a) Informant Ella V. Chambers
(b) Address 2712 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 7 1944 (month, day, year)
(c) Cemetery or crematory Mt Carmel
Location Littlestown Pa.

18 (a) Funeral director Ellsworth Rosenwald
(b) Address 314 Liberty Hgts. Ave

19 (a) AUG 5 - 1944 (Date rec'd by registrar) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1944 at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1944 to Aug 4 1944. and that I last saw h. alive on Aug 4 1944.

Immediate cause of death Cardiac Failure — Duration
Due to Congestive Heart Failure
Due to Fracture left hip
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 2712 Hickory Ave. Aug. 2 1944
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no (Specify type of place)
(e) Means of injury: Slipped and fell at home

23. Signature William H. Luppert M. D.
Address Union Memorial Hosp Date signed 8/4/44

Approved: Robert Lee Slater M.D. Aug. 5 1944

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19611 Mamie Adams
3 1/2 3rd St

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

$3a

G19611 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 632 N. Caroline St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 632 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George E. Palmer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1891

8. AGE: Years 52 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Lloyd Lewis
13. Birthplace Md.

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Rosaman Palmer
(b) Address 632 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-5-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Eutaw St & Huntington Ave

19 AUG 5 - 1944 (b) (Rec'd by Registrar) Registrar

VS 150

8/2/44

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-2-44 19 , at 3:55 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31-44 19 to 8-2- 19 44, and that I last saw h[illegible] alive on 8-1- 19 44

Immediate cause of death Cerebral Hemorrhage — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Adams, M. D.
Address 312 E 23rd St Date signed 8-4-44

G19612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

G19612 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1808 Mullen St
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 Mullen St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Hall Ley ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Hall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1895

8. AGE: Years 49 | Months 7 6 | Days 17 | If less than one day hr. min.

9. Birthplace Augusta Georgia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Walter Hall
13. Birthplace Ga

MOTHER 14. Maiden Name Alice Hall
15. Birthplace Ga

16 (a) Informant Ethel Hall
(b) Address 1724 Orlean St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 6 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 AUG 5 - 1944 (Date rec'd by registrar) (b) Huntington Ave, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1944 at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15, 19XX to 8-2- 1944, and that I last saw him alive on Aug 1, 19XX.

Immediate cause of death: Uremia

	Duration
Due to:	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin Adams, M. D.
Address 312 E 23rd St Date signed 8-4-44

VS 180

G19613

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G19613 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 Druid Hill Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isadora Agoma Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1891

8. AGE: Years: 53 | Months: 1 | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Benjamin D. Scroggins

13. Birthplace Carroll Co. Md

MOTHER 14. Maiden Name Louisa R. Carroll

15. Birthplace Carroll Co. Md.

16 (a) Informant James F. Williams

(b) Address 1927 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 5, 1944 (month) (day) (year)

(c) Cemetery or crematory Greater Love

Location Baltimore, Md.

18 (a) Funeral director Mrs. Lee W. Holland

(b) Address 1621 Druid Hill Ave

19 AUG 5 - 1944 (Date rec'd by registrar) Thurlington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2- 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1- 1944 to 8-2- 1944, and that I last saw h[illegible] alive on 8-1- 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	10 hrs
Due to Hypertension	
Due to Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: — no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature Wm. R Boykin M.D.

Address 1135 Gilmor Date signed 8/5/44

VS 150

G19614
456060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57e

G19614
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ala. (b) County
(c) City or town Garland
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Kendrick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife John Kendrick
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 3-11-86

8. AGE: Years	Months	Days	If less than one day
58	4	24	hr. min.

9. Birthplace Ala.
(Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Madison Joyner
13. Birthplace Ala.

MOTHER
14. Maiden Name Frances Ethridge
15. Birthplace Ala

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 8/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Concord County
Location Evergreen, Alabama
18 (a) Funeral director John D. Mitchell Funeral Home
(b) Address 1909 Eutaw Place
AUG 6 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 5 1944. at 3.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July-24 1944. to Aug-5 1944, and that I last saw her alive on Aug-5-1944.

Immediate cause of death Brain Tumor — Duration 5

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Aug 1, 1944
Major findings of operations: Brain Tumor
of autopsy: Brain Tumor

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugo V. Rizzoli M. D.
Address Johns Hopkins Hosp. Date signed 8-5-44

G19615

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 46E

G19615 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Augusta, R. F. D. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Blanche Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Charles L. Baker

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 1872

8. AGE: Years 72 | Months 3 4 | Days | If less than one day: hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Thomas Dallas Coghill

13. Birthplace Va.

MOTHER 14. Maiden Name Mary Campbell

15. Birthplace Va.

16 (a) Informant Charles L. Baker

(b) Address Augusta, Ga. R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)

(c) Cemetery or crematory Westover Memorial Park

Location Augusta, Ga.

18 (a) Funeral director John O. Mitchell Sons Inc.

(b) Address 1900 Eaton Place

19 (Date received by registrar) AUG 6 - 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5th - 1944, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 3rd 1944 to Aug 5 1944, and that I last saw her alive on 19

Immediate cause of death Cardiac failure — Duration

Due to

Due to Ca of transverse colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. H. Zuya Jr. M. D.

Address St Agnes Hosp. Date signed

G19616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G19616 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Richwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 Richwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan M. Richardson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Dr Henry Richardson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1865

8. AGE: Years 79 | Months 4 | Days 19 | If less than one day hr. min.

9. Birthplace St Marys Co.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Dent
13. Birthplace St Marys Co, Md.

MOTHER 14. Maiden Name Emma Hammett
15. Birthplace St Marys Co, Md

16 (a) Informant Stewart G, Robinson
(b) Address 700 Richwood Ave

17 (a) Burial (b) Date thereof Aug 7, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Trinity P.E. Cemty
Location St Marys City, Md

18 (a) Funeral director John O. Mitchell Undertaking Co
(b) Address 1900 Eutaw Place
AUG 5 - 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Aug 4 1944, and that I last saw h.. alive on Aug 2 1944.

Immediate cause of death — Duration
Myocardial failure — 2 days
Due to Cardio-vascular-renal disease — few yrs
Due to
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Bowman Gerlach M. D.
Address 2200 Garrison Blvd Date signed 8/6/44

458603 G19617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G19617 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Church Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Keene.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Frances.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-23-05

8. AGE: Years	Months	Days	If less than one day
39	4	22	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Insurance Agent.
11. Industry or business

FATHER
12. Name Charles H Keene
13. Birthplace Md.

MOTHER
14. Maiden Name Willa B Keene
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8-44 (month) (day) (year)
(c) Cemetery or crematory
Location Cambridge Md

18 (a) Funeral director Granville S LeCompte
(b) Address Cambridge Md

19 AUG 6 1944 (b) Huntingtown Md (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 5 1944, at 5.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 3 1944, to Aug 5 1944, and that I last saw him alive on Aug - 5 1944.

Immediate cause of death: Lobar pneumonia — Duration: 2 days
Due to: Pneumococcus Type 3
Due to: Empyema, right, Type 3
Other Conditions: Septicemia c Type 3
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Birmingham M.D.
Address J H H Date signed

G19618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G19618 Registered No. 46B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Edward H. Wells

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Macy Welk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1874

8. AGE: Years	Months	Days	If less than one day
69	10	8	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Paperhanger

11. Industry or business

FATHER
12. Name Henry Welk
13. Birthplace Maryland

MOTHER
14. Maiden Name Sevilla Starner
15. Birthplace Maryland

16 (a) Informant Clarence Welk
(b) Address Westminster, Md R.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Pleasant Valley
Location Pleasant Valley Md.

18 (a) Funeral director C. O. Sens & Son
(b) Address Taneytown, Md

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1944 19 , at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26-44 19 , to 8-5-44 19 , and that I last saw him alive on 8-5-44 19 .

Immediate cause of death: Cerebral hemorrhage — Duration

Due to —

Due to —

Other Conditions Carcinoma of stomach

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. H. Haynes

Address Md. Gen'l Hosp. Date signed 8/6/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19619

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19619 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 S. Ellwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 S. Ellwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary B. Pisnicki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Peter Pisnicki

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1866

8. AGE: Years	Months	Days	If less than one day hr.	min.
77 78	11	14		

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mr Edmund Pisnicki
(b) Address 607 S. Ellwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 461 S. Chester Street

19 (a) AUG 6 1944 (Date rec'd by registrar) Wilmington, Delaware, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 2 1944, at 11 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Aug 2 1944 and that I last saw h alive on Aug 2 1944

Immediate cause of death Coronary Thrombosis

	Duration
Due to Ch. Myocarditis	Aug 1944
Due to Arterio Sclerosis	3/1944
	1940
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J Cramer
Address 801 E Lexington Date signed Aug 6 1944

G19620 ~~-D~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$2

G19620

Registered No. H19620

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2321 Riggs Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2321 Riggs Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Ann Yoe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Melvin J. Yoe

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) Sept 25, 1914

8. AGE: Years	Months	Days	If less than one day
29	10	9	....hr. ....min.

9. Birthplace Baltimore, County (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER — 12. Name William H Rosemark

13. Birthplace Baltimore

MOTHER — 14. Maiden Name Lena M. Hoffman

15. Birthplace Baltimore

16 (a) Informant Mrs. Melvin Yoe

(b) Address 2321 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-44 (month) (day) (year)

(c) Cemetery or crematory Lorraine

Location Balto. County

18 (a) Funeral director Frederick A. Cole

(b) Address 1200 W Lombard St

19 (a) AUG 6 1944 (Registrar) (b) Huntington Woods, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1944, at 4 30 A.M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pyelonephritis, chronic suppurative, right

Due to Transverse myelitis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ....at.... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Act Medical Examiner.
Date signed 8-5-44

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G19621 1/

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 45a

G19621

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st S.
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.2mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 1yr.2mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Wisconsin (b) County
(c) City or town Prescott
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE PETER LORENTSEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1883

8. AGE: Years	Months	Days	If less than one day
60	7	5	hr. min.

9. Birthplace Prescott, Wisconsin (Town, county, and state)
10. Usual Occupation Mate 1/c
11. Industry or business

FATHER
12. Name Peter Lorentsen
13. Birthplace Denmark

MOTHER
14. Maiden Name Dorothy Peterson
15. Birthplace Denmark

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Prescott, Wisconsin

18 (a) Funeral director Frederick P. Cole
(b) Address 1200 W. Lombard St.

19 (a) Filed by registrar (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1944, at 5:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 30, 1943, to Aug. 5, 1944, and that I last saw him alive on Aug. 5, 1944.

Immediate cause of death
Squamous cell carcinoma of the lower lip with multiple metastases in the skin nodes and tissues of the neck — Duration 3 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 6/2/43
Major findings of operation: Radical lymphadenectomy. Partial resection of mandible. Radical resection of recurrent cancer involving tissues of left side of face
Results of autopsy: As above

PHYSICIAN
Underline the cause on which death should be entered statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature F K Allocca M.D.
Address US Marine Hospital, Baltimore, Md. Date signed 8/5/44

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131a

G19622

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st Street
(c) Hospital or institution:
US Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d.
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hotel Burlington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ZENOBIA MOORE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widowed

6 (b) Name of husband or wife Admiral James M. Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 28, 1860

8. AGE: Years	Months	Days	If less than one day
83	9	6	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George Gandren
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8-1944 (month) (day) (year)
(c) Cemetery or crematory Arlington Natl Cem.
Location Arlington Va

18 (a) Funeral director Taft & B. M. Walters
(b) Address Pratt & Stricker Sts

AUG 6 - 1944 (Date rec'd by registrar) (Huntington Williams M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1944, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9, 1944, to Aug. 4, 1944, and that I last saw him alive on Aug. 4, 1944.

Immediate cause of death	Duration
Diffuse marked arteriosclerosis with localized sclerosis of the xxxcircle of Willis, the coronary	Unknown.
Due to xxxxde, eneration involving the basal ganglia and surrounding brain substance.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. A. Aldrich M. D.

Address US Marine Hospital, Baltimore, Maryland Date signed 8/5/44

G19623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19623 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town North Linthicum (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles & Eleanor Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Diane Muzzucco

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1942

8. AGE: Years 21 | Months 10 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Md. Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joseph Muzzucco
13. Birthplace St Steffin, Italy

MOTHER
14. Maiden Name Evelyn Greenwell
15. Birthplace Hollywood Md.

16 (a) Informant Joseph Muzzucco
(b) Address Linthicum, Md. R.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Hgway A.A. County, Md.

18 (a) Funeral director Thomas W. Burgliter
(b) Address Glen Burnie, Md.

19 (a) ... (b) ... Registrar

AUG 6 - 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1944 at 6:22 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31 1944 to 8/5 1944 and that I last saw h.i.m alive on 8/5 1944.

Immediate cause of death Rocky Mt. Spotted Fever

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Md. Gen. Hosp. Date signed 8/5/44

G19624

T.C.P.-69260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19624 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 370 Forrest Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carmella Brocato

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Vincent Brocato
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 10th. 1861

8. AGE: Years: 83 ? Months: 2 Days: 2x25 If less than one day: hr. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: home

FATHER
12. Name: Joseph ? Di Fatta
13. Birthplace: Italy

MOTHER
14. Maiden Name: XXXXX Dia Tamburo
15. Birthplace: Italy

16 (a) Informant: Baltimore City Hospitals
(b) Address: Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 7/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location: Belair Rd. Balt. Md.

18 (a) Funeral director: Fanelli Bella Hoer.
(b) Address: 52 N. Morley St. Huntington Williams, Md.

19. (a) 1944 (Filed by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1944 19 , at 2:25AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 19 44 to 8/4 19 44, and that I last saw her alive on 8/4 19 44.

Immediate cause of death	Duration
Congestive heart failure	3 mos.
Due to Hypertensive cardiovascular disease	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Shea Hulle
Address BCH Date signed 8/4/44 M. D.

G19625 BALTIMORE CITY HEALTH DEPARTMENT G19625

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED: Carroll
(a) State Md (b) County Baltimore City
(c) City or town Medford, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John David Baile

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nora Louise Baile
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 16, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Merchant
11. Industry or business

FATHER
12. Name Mr. Jesse Baile
13. Birthplace Maryland

MOTHER
14. Maiden Name Anne Louise Henglar
15. Birthplace Maryland

16 (a) Informant Admission
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9 44 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch Cem
Location Westminster, Md.

18 (a) Funeral director J. S. Myers, Jr.
(b) Address Westminster, Md.

19 (a) (Registrar) (b) Huntington Millington, Md.

AUG 6 - 1944
Vs 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6 1944, at 6 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 1944, to 8-6 1944, and that I last saw him alive on 8-6 1944.

Immediate cause of death Cardio Resp Failure — Duration

Due to Hypostatic pneumonia

Due to

Other Conditions Multiple Myeloma

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D.
Address UMH. Date signed 8-6-44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G19626
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered, or the word "unknown" or the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Jasper St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Jackson Stewart (MARSHALL)

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Geo. Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-31-1894

8. AGE: Years 50 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Housework

11. Industry or business

FATHER
12. Name: Andrew Jackson
13. Birthplace: Va.

MOTHER
14. Maiden Name: Susan Snead
15. Birthplace: Va.

16 (a) Informant: Evelyn Nichols
(b) Address: 711 Edmondson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem
Location: Baltimore Md

18 (a) Funeral director: William A. Jackson
(b) Address: 916 Pennsylvania Ave. Huntington Park, Baltimore, Md.

AUG 6 - 1944 (Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carcinoma of Breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollenweber M.D.
Medical Examiner.
Date signed 8-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19627 BALTIMORE CITY HEALTH DEPARTMENT G19627
CERTIFICATE OF DEATH 1318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Brewer St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Hughes Richardson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lee
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8-25-1904

8. AGE: Years 39 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER 12. Name Richard Johnson
13. Birthplace Md.

MOTHER 14. Maiden Name Fannie Toomey
15. Birthplace Md.

16 (a) Informant Lee Richardson
(b) Address 1125 Brewer St

17 (a) Burial (b) Date thereof 8-5-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) AUG 6 1944 (b)
(Registrar)
VS 150

Huntington Williamsport, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3-44 19 at 3 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23-44 19 to 8-3-44 19, and that I last saw her alive on 8-3-44

Immediate cause of death: Uremia. — Duration

Due to: Chr. Glomerulo Nephritis

Due to:

Other Conditions: Cardiac Failure
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Hunter Neal, M.D. M. D.
Address Univ. Hosp. Date signed 8-4-44

G19628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G19628 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Sidney Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WARREN John BELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emilie Bell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3, 1891

8. AGE: Years	Months	Days	If less than one day
53	—	2 3	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Stuckster
11. Industry or business Self

FATHER
12. Name Charles Edward Bell
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sophia Seifert
15. Birthplace Balto. Md.

16 (a) Informant Emilie Bell
(b) Address 2101 Sidney Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George V. Schwed
(b) Address 2101 Frederick Avenue

AUG 6 - 1944 (Date rec'd by registrar) (b) Huntington Millennium, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944, at 3 35 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-6-44 at 25/3 M.
(b) Where did injury occur? Westport Harbor
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury drowning while bathing

23. Signature H. L. Wallenmeyer M.D.
and Medical Examiner.
Date signed 8-6-44

G19629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G19629
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Sidney Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WARREN E BELL [redacted]

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/1912

8. AGE: Years 31 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Warren J. Bell
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Emilie Doeller
15. Birthplace Balto. Md.

16 (a) Informant Emilie Bell
(b) Address 2101 Sidney Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9. 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Geo. F. Schmelz
(b) Address 211 Fredrick avenue

AUG 6 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944, at 10 a M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-6-44 at 10 a 25/3 M.
(b) Where did injury occur? Westport harbor
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Boat returning

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 8-6-44

G19630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19630
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elias Zwerling

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Rachael

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1856

8. AGE: Years 88 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Meyer
13. Birthplace Russia

MOTHER 14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Harry Zahne
(b) Address 2817 Hockrow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Phil Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 439 E. Balto St.

19 (a) 6 AUG 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5-1944, at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1925 to Aug. 5 1944 and that I last saw h alive on Aug 5 1944.

Immediate cause of death	Duration
myocardial insufficiency	6 yrs
Due to	
Due to arteriosclerosis	20 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Levitan M. D.
Address 1720 Eutaw Pl. Date signed Aug 6 1944

G19631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19631 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st Street
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 da
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Tangier
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY THOMAS MCCREADY

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Bessie Crockett
6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1908

8. AGE: Years	Months	Days	If less than one day
36	7	0	..... hr. ..... min.

9. Birthplace Tangier, Virginia
(Town, county, and state)
10. Usual Occupation Ord. Seaman
11. Industry or business

FATHER
12. Name Sidney McCready
13. Birthplace Tangier, Virginia

MOTHER
14. Maiden Name Elizabeth Crockett
15. Birthplace Tangier, Virginia

16 (a) Informant RECORDS *US MARINE HOSPITAL
(b) Address BALTIMORE, MARYLAND

17 (a) Burial (b) Date thereof 8/8/44
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery Parks
Location Tangier Island Va.

18 (a) Funeral director Fairfield & Landstreet
(b) Address 30 Main St, Crisfield Md.

19 (a) AUG 6 1944 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5, 1944, at 2.45pM

21. I certify that death occurred on the date above stated; that I attended deceased from July 22, 1944, to Aug. 5, 1944, and that I last saw him alive on Aug. 5, 1944.

Immediate cause of death	Duration
Hypertensive cardio-vascular disease with uremia	1 wk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. T. McCready M. D.
Address US Marine Hospital Date signed 8/6/44
Baltimore, Maryland.

G 19632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164c

Registered No. G 19632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) /

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore Co. Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. York Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Norman E. Bosley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Catherine Bosley

6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) Mar. 24 1915

8. AGE: Years	Months	Days	If less than one day
29	4	16	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business R. E. Campbell Sons

FATHER
12. Name Thomas Bosley
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Emma Hale
15. Birthplace Baltimore Co. Md.

16 (a) Informant Mrs Norman E. Bosley
(b) Address Cockeysville Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-44 (month) (day) (year)

(c) Cemetery or crematory Jessops
Location Sparks

18 (a) Funeral director Linden M. Brooks
(b) Address Sparks Md.

AUG 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944 10:30 at A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suicide

Due to Bullet wound of head.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-6-44 at 7:10 A. M.
(b) Where did injury occur? Woodburne Ave. Yolden Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot self with rifle

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed August 10 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. That age is especially important. Physicians: please write the causes of death clearly and legibly.

G19633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56B

G19633
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME (CORRECT) Mrs Ora J. Lloyd.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-01-3516

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Robert E. Lloyd

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30 1896

8. AGE: Years	Months	Days	If less than one day
47	11	5	hr. min.

9. Birthplace Meyersdale, Pa.
(Town, county, and state)

10. Usual Occupation Tailoring
11. Industry or business English American Tailoring Co-Inc

FATHER
12. Name John S. Johnson
13. Birthplace Garrett Co. Pa.

MOTHER
14. Maiden Name Susan M. Hostetler
15. Birthplace Garrett Co. Pa.

16 (a) Informant Robert E. Lloyd
(b) Address 38 N. Bentalou St.

17 (a) Burial (b) Date thereof Aug 7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director G. Howard Storey
(b) Address 3707 W. North Ave.

AUG 8 1944
(Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4 1944, at 3:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1944, to 8/4 1944, and that I last saw h. alive on 8/4 1944.

Immediate cause of death Cardiac failure

Due to —

Due to —

Other Conditions Asthmatic — pyelitis.
(Include pregnancy within 3 months of death)

Date of operation 7/24/44

Major findings of operations: Myomata uteri obliterated appendix.

of autopsy: —

Duration
1 hr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature William J. Mitchell M.D. M. D.

Address Md. Gen. Hosp. Date signed 8/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered or the word "unknown" supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19634 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 23 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 314 Brookfield ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Albert Piekarski Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 8-4-44 - 4 days
8. AGE: Years | Months | Days | If less than one day: 23 hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Albert Piekarski
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Mary Elizabeth Pentzeiter
15. Birthplace Baltimore Md.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Md.

18 (a) Funeral director Guy-A-Furley
(b) Address Fulton & Fayette

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4- 1944 to 8-5 1944 and that I last saw him alive on 8-5 1944.

Immediate cause of death: Intracranial Hemorrhage — Duration

Due to Prolapsed Cord

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Vogel Jr. M. D.
Address Bon Secours Hosp. Date signed 8-5 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19635
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 East Biddle Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 East Biddle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose C. Connelly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward C. Connelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years 41 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)

10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Peter Buchocz
13. Birthplace

MOTHER
14. Maiden Name Katherine White
15. Birthplace

16 (a) Informant Mrs. Edward C. Connelly
(b) Address 721 East Biddle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Mary M. Shufeldt
(b) Address [illegible]

AUG 6 - 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4th 1944, at 7:10 P

21. I certify that death occurred on the date above stated; that I attended deceased from August 4/44 to 8/4 1944 and that I last saw her alive on Aug 4 1944.

Immediate cause of death	Duration
Acute Cerebral Hem	an hr.
Due to Ch Hypertension.	
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. L. Hornstein M. D.
Address 733 Ampsith St Date signed 8/5/44

G19636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19636 Registered No. 13 1a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 608 East 27th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 East 27th, Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E. Lyston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Bridget Lyston
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1843 1863

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Balto., Co.
(Town, county, and state)
10. Usual Occupation Clerk,
11. Industry or business

FATHER
12. Name James Lyston
13. Birthplace Ireland

MOTHER
14. Maiden Name B. Brassell
15. Birthplace Ireland

16 (a) Informant Mrs. W.E.Lyston
(b) Address 608 East 27th Street

17 (a) Burial (b) Date thereof 8/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Mary M. Heidfeld
(b) Address 5[illegible] E 33rd Street

19 (a) Date received AUG 6 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4th 1944 at 7:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to Aug. 4 1944
and that I last saw h[illegible] alive on Aug 3. 1944.

Immediate cause of death: Chronic Myocarditis — Duration 3 yrs.
Due to Arteriosclerotic Cardiovascular Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel J. Wolfe
Address 1331 E. North Ave Date signed 8-5-44 M.D.

G19637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G19637

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 Chapel Gate Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie L. Lockard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Louis E Lockard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-29-1872

8. AGE: Years 72 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name William J. Winters
13. Birthplace Ireland

MOTHER
14. Maiden Name Lucy Campel
15. Birthplace Ireland

16 (a) Informant Estelle Nolan
(b) Address 205 Rock Glen Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-7-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Edw. S. MacNabb
(b) Address Fairmont & Woodlawn

19 (Date rec'd by registrar) AUG 7 - 1944 Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3 1944, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1942, to 8/3 1944, and that I last saw her alive on 8/3 1944.

	Duration
Immediate cause of death: Cardio-Pulmonary Insufficiency	1 mo.
Due to: Generalized Arteriosclerosis	10 yr.
Due to:	
Other Conditions: Diabetes Mellitus	10 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Malcolm K. Gallagher M.D.
Address Catonsville, Md. Date signed 8/6/44

G19638

T.G.P.- 89007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52 B

Registered No. G19638

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 North Howard Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Smithson, Bessie

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1879

8. AGE: Years 64 | Months 5 8 | Days 20 | If less than one day: hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name William Bird
13. Birthplace Maryland

MOTHER: 14. Maiden Name Sally Fisher
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 8-44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Overdale, Md. Rural

18 (a) Funeral director Ray A. Patterson Funeral Home
(b) Address Perry Valley Md. Thurmont, Md.

19 (Date received by registrar) AUG 7 - 1944 Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1944 19 , at 5:25 P M

21. I certify that death occurred on the date above-stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Papillary Carcinoma of Bladder with metastasis — Duration: terminal

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hauck E. Dalton
Address Balt. City Hosp. Date signed 8/6/44 M D

G19639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G19639

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Mason ct (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN CRAWFORD

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Haseltine
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Aug 13, 1912
8. AGE: Years 31 | Months 11 | Days 22 | If less than one day: hr. min.
9. Birthplace: Hollins Va (Town, county, and state)
10. Usual Occupation: Carman
11. Industry or business: Coal
FATHER 12. Name: SAMUEL CRAWFORD
13. Birthplace: Va
MOTHER 14. Maiden Name: IDA RILEY
15. Birthplace: Va
16 (a) Informant: HASELTINE CRAWFORD
(b) Address: 225 Mason Court
17 (a) Burial, cremation, or removal: Burial (b) Date thereof: 8/6/44 (month) (day) (year)
(c) Cemetery or crematory: HOLLINS
Location: HOLLINS, Va
18 (a) Funeral director: Wilhem & Son Inc
(b) Address: 1244 W Pratt St
19 AUG 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 19 44 at 1 45 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-4-44 at 6 45 PM
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury: fell from 2nd to 1st floor
23. Signature: H. A. Wallenmeyer M.D. Asst Medical Examiner.
Date signed 8-6-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered, and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G19640

T.C.P.--87968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G19640

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 871 N. East Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Vivian Ingerson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Try Ingerson (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1887

8. AGE: Years	Months	Days	If less than one day
57	3	4	hr. min.

9. Birthplace Maine (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Bert Ingerson
13. Birthplace Maine

MOTHER: 14. Maiden Name Eleanor LaSalle
15. Birthplace Maine

16 (a) Informant Baltimore City Hospital
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Morland Park
Location Parkville Md.

18 (a) Funeral director William Cox Inc
(b) Address 1317 St. Paul St.

19 AUG 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1944 19..., at 3:15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/12 1944 to 8/5 1944, and that I last saw h e alive on 8/5 1944

Immediate cause of death: Adenocarcinoma of ovary with metastasis

Duration
Unknown

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hauck E. Bolton
Address Balt. City Hosp. Date signed 8/5/44

G19641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1245

G19641

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS STUMP

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1888

8. AGE: Years 55 60 | Months 9 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Citrus Grower
11. Industry or business

FATHER
12. Name Frank Stump
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna Scott
15. Birthplace Baltimore Md

16 (a) Informant John Stump
(b) Address 298 N Mosby St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore Md

18 (a) Funeral director Wilson & Pace
(b) Address 1214 St Paul St

19 AUG 7 - 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION 15

20. DATE OF DEATH August 4, 1944, at 10:P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to him death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured esophageal Varices

Due to Cirrhosis of Liver

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Aug. 5 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FO

G19642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 B

Registered No. G19642

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 44 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 No. Charles St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Flossie M. Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1897

8. AGE: Years	Months	Days	If less than one day
46	11	8	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Telephone Operator

11. Industry or business

FATHER
12. Name Walter B. Criddle
13. Birthplace Virginia

MOTHER
14. Maiden Name Dora S. Morris
15. Birthplace Virginia

16 (a) Informant Herbert G Criddle
(b) Address 2202 N. Calvert

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md

18 (a) Funeral director Nelson Cook Inc
(b) Address 1217 E. Cary St.

19 (a) AUG 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1944, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1944 to Aug 5 1944 and that I last saw her alive on Aug 5 1944.

Immediate cause of death	Duration
Chronic glomerulo nephritis	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy: Ascites, Pleural effusion. Uremia. Edema. Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stephen J Van Lill M.D.
Address Union Memorial Hosp. Date signed 8-7-44

G19643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77

G19643 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W. Read St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERTHA LANGDON KLINGAMAN

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F E M	W	WIDOW

6 (b) Name of husband or wife: William H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 22, 1889

8. AGE: Years	Months	Days	If less than one day
55 Yrs	5	10 12	hr. min.

9. Birthplace: Ga
(Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: George Bable
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Ireland

16 (a) Informant: William L. Klingaman
(b) Address: 12 W Read St

17 (a) Removal (b) Date thereof 8/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Lancaster
Location: Lancaster Pa

18 (a) Funeral director: Wilson Co Inc
(b) Address: 1219 E Lexington St

19 (a) AUG 7 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1944 at 10 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Alcoholism
?
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williamson M.D.
Asst Medical Examiner.
Date signed 8-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

Registered No. G19644

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 24 hrs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5701 Rusk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicklas, Wesley

3 (b) If veteran, name war: NW
3 (c) Social Security Account No. NAF

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 26, 1937

8. AGE: Years	Months	Days	If less than one day
6	9	9	hr. min.

9. Birthplace New York (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name John M. Nicklas
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elsie Little
15. Birthplace Baltimore

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) 1907 - 1944 St Paul St Huntington Williams, M.D.

19 (a) AUG 7 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1944 at 8:27 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1944, to 8-5 1944, and that I last saw h[illegible] alive on 8-5 1944.

Immediate cause of death	Duration
bulbar poliomyelitis	1 day
Due to	
Due to	
Other Conditions mediastinal tuberculosis (Include pregnancy within 3 months of death)	

Date of operation tracheotomy 8-5-44
Major findings of operation:
of autopsy: Sutne

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret N.D. Smith M.D.
Address Sydenham Hosp Date signed 8-8-44

G19645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G19645 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6204 Blackburn Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6204 Blackburn Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JENNIE DONOVAN BRAUN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry William Braun
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-1874

8. AGE: Years 70 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Donovan
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Elizabeth Stansbury
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss. Mary Elizabeth Stansbury
(b) Address 6204 Blackburn Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8- 7-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Baltimore

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address 1941 Eutaw Ave. & Broadway

AUG 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 3 1944 8.50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 3 1944 and that I last saw her alive on Aug 3 1944

Immediate cause of death: Chronic Interstitial Nephritis — Duration: Years
Due to: Arteriosclerosis — Years
Due to: High Blood Pressure — Years
Due to: Myocarditis — Years
Other Conditions: Influenza — 1 yrs
Senility Depression — 2 yrs
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred L. Zimmerman, M.D.
Address 9858 Harford Rd Date signed 8/4/44

G19646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G19646 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 GUILFORD AVE
(c) Hospital or institution:
NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE CITY.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 GUILFORD AVE
(If rural, give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME LULU MAY CROWDER.

3 (b) If veteran, name war

3 (c) Social Security Account No. [illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	WIDOW

6 (b) Name of husband or wife EDWARD A. CROWDER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/21/1869

8. AGE: Years	Months	Days	If less than one day
75	2	13	hr. min.

9. Birthplace PETERSBURG, VA.
(Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name WILLIAM P. WRIGHT
13. Birthplace VA.

MOTHER
14. Maiden Name MARY ?
15. Birthplace VA.

16 (a) Informant MR. ORVILLE W. CROWDER
(b) Address 2910 GUILFORD AVE.

17 (a) BURIAL (b) Date thereof 8/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PK. CEM.
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) (b)
(Signature) (Date received) (Year)
AUG 7 - 1944 Huntington-Williamsburg, Md.

MEDICAL CERTIFICATION P

20. DATE OF DEATH AUGUST 4. 1944 19 , at 9.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from AUG 3 1944. to AUG 4 1944. and that I last saw h.er alive on AUG 4 19 44.

Immediate cause of death	Duration
ACUTE CARDIAC DILITATION AUG	3 1944
Due to CHRONIC MYOCARDITIS	1940
Due to ARTERIOR SCLEROSIS	1940.
Other Conditions FRACTURE OF LEFT FEMUR 1939.	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas P Chandler
Address 3013 SAINT PAUL STREET. Date signed AUG 5 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 Trans G19647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G19647 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 - De Sota Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ogle
3 (b) If veteran, name war
(c) Social Security Account No.

4. Sex: Male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of ~~husband~~ wife Sadora Kinsey
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 15, 1853
8. AGE: Years 90 | Months 10 | Days 10 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George W. Ogle
13. Birthplace England

MOTHER
14. Maiden Name Anna Adams
15. Birthplace England

16 (a) Informant Mrs Theodore Ogle
(b) Address 905 De Sota Rd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.
18 (a) Funeral director Harry A. Witzke
(b) Address 4016 Edmondson Ave
19 (a) (Date received by registrar) AUG 7 - 1944 Huntington Williams Md. (Registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1944, at 3:50 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1944 to 8/5 1944, and that I last saw h[illegible] alive on 8/5 1944.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Fract Neck Femur	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 25/2
(b) Date of occurrence July 25, 1944 at M
(c) Where did injury occur? Baltimore Md (City or town) (County) (State)
(d) Did injury occur abut home, on farm, industrial place, in public place? Public While at work? No (Specify)
(e) Means of injury Fell on sidewalk in front of home
23. Signature E. L. Raffucci-Allen M. D.
Address St. Agnes Hosp Date signed 8/5/44

G 19648

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G 19648

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 N. Gay St. (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Wilmer

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-22-44

8. AGE: Years	Months	Days	If less than one day
			9 hr. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address JOHNS HOPKINS HOSPITAL

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL AUG 24 1944

18 (a) Funeral director Commissioner of Health
Address.....

AUG 7-1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1944 at 2.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 19 44 to July 22 19 44 and that I last saw him alive on July 22 19 44.

Immediate cause of death prematurity

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp. Date signed 7-22-44

12072

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Try to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19649

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 83a

G19649
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2609 Edmondson ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Dorchester
(c) City or town Leamtridge Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emma Willey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph A. Willey
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) Jan 16-1876

8. AGE: Years	Months	Days	If less than one day
68	6	22	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Josiah McGrath
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Susan Mills
(b) Address 2609 Edmondson ave

17 (a) Buried (b) Date thereof Aug 9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Memorial Park
Location Cambridge Md

18 (a) Funeral director Ingerville & Compton
(b) Address Cambridge Md

19 (a) (b)
(Date rec'd by registrar) (Signature of Registrar)
AUG 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6-44 19 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-1-42 19 to 8-6-44 19 and that I last saw h 24 alive on 8-5 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 wks
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry S. Trimble M. D.
Address 2703 Edmondson Date signed 8-6-44

G13650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G19650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2013 Ashton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2013 Ashton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Veitchman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Abaham Veitchman

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) July 5 1892

8. AGE: Years 52 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business at home

FATHER 12. Name Nehemyah Veitzer

13. Birthplace Russia

MOTHER 14. Maiden Name Fruma -

15. Birthplace Russia

16 (a) Informant Abraham Veitchman

(b) Address 2013 Ashton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-44 (month) (day) (year)

(c) Cemetery or crematory Workman Circle Com

Location Hebrew Mt. Carmel

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto St

AUG 7 - 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6-44 19 , at 11 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944, to Aug 6 1944, and that I last saw ~~him~~ her alive on Aug 6 1944.

Immediate cause of death Cancer of left lung — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Kader M. D.
Address 2306 Eutaw Pl Date signed 8-6-44

KADER

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19651

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157M Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2838 Oakley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Frankel.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Wh | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22-1944

8. AGE: Years | Months | Days: 16 | If less than one day: hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Harry Frankel
13. Birthplace Balto

MOTHER
14. Maiden Name Florence Berman
15. Birthplace Balto

16 (a) Informant Harry Frankel
(b) Address 2838 Oakley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-44 (month) (day) (year)
(c) Cemetery or crematory Wellman Circle
Location Hebrew Cem. Carmel

18 (a) Funeral director Jos Lewis Inc
(b) Address 1439 E. Balto St.

(c) Date received AUG 7 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944, at 11:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1, 1944 to Aug 6, 1944 and that I last saw h. alive on Aug 6, 1944

Immediate cause of death	Duration
Uraemia	
Due to Pyelonephritis	
Due to Congenital hydroureter & hydronephrosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Murray Soiffer M. D.
Address Sinai Hosp Date signed Aug 6, 1944.

G19652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G19652 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1531 N. Smallwood St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Davis, Mr. Henry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Edith Davis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 12 1901
8. AGE: Years 42 | Months 9 | Days 25 | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Isaac Davis
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Schwartz
15. Birthplace Russia

16 (a) Informant Edith Davis
(b) Address 1531 N. Smallwood St Balt.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-44 (month) (day) (year)
(c) Cemetery or crematory Mishkan Israel
Location Equilbeck Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 AUG 7 – 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1944, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to Aug 6 1944, and that I last saw him alive on Aug 6 1944.

Immediate cause of death: Carcinoma of rectum with Metastases to the liver — Duration: ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 7-24-44
Major findings of operation: As above
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John M. Cullen
Address Church Home & Hospital Broadway & Fairmount Baltimore, Md. Date signed 8-6-44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19653 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Lurndale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2815 Rockrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ISRAEL HOFFMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife FRIEDA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ABRAHAM
13. Birthplace RUSSIA

MOTHER
14. Maiden Name GETTLE
15. Birthplace RUSSIA

16 (a) Informant AGED HOME
(b) Address

17 (a) BURIAL (b) Date thereof 8-7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B'NAI ISRAEL
Location SOUTHERN AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1437 E. BALTO ST.

AUG 7 - 1944 (b) Huntington Avenue, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6 1944, at 11.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8-6 1944, and that I last saw him alive on 8-6 1944.

Immediate cause of death	Duration
Broncho-pneumonia	8-4-44
Cerebral vascular disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edmund Lewis M. D.
Address Lurndale Date signed

G19654 - 89228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G19654
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1545 Leslie St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertie Wright (Bertha)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Tenck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17, 1881

8. AGE: Years 63 | Months 0 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Daniel Collins
13. Birthplace N. C.

MOTHER — 14. Maiden Name Mary Young
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director George A. Kelson
(b) Address 1303 Brustmann St

AUG 7 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1944, at 6:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31, 1944, to Aug. 3, 1944, and that I last saw her alive on Aug. 3, 1944.

Immediate cause of death Cardiac ... Duration

Due to Arteriosclerosis ...

Due to Hypostatic Congestion Pneumonia ...

Due to ...

Other Conditions ...
(Include pregnancy within 3 months of death)

Date of operation ...

Major findings of operation: ...

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ...
(Specify type of place)
(e) Means of injury ...

23. Signature H. M. Phillips M. D.
Address Balt. City Hosp. Date signed 8-3-44

G19655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

G19655 Registered No.

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be clearly given. Do not abbreviate. Use no ditto marks. Be sure to write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hosp. for the Women of Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 N Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Healy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	24 hr. 20 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Mr James K Healy
13. Birthplace McDonald, Pa.

MOTHER
14. Maiden Name Eileen Mary League
15. Birthplace Baltimore, Md.

16 (a) Informant James K. Healy
(b) Address 1427 N. Milton Ave

17 (a) Burial (b) Date thereof 8-7th 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Leo G. Leach
(b) Address 1701-03 N. Patterson Park Ave

19 (a) (Date received by registrar) AUG 7 - 1944 (b) Registrar's signature Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1944, at 10:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 AM 8/4 1944, to 10:45 PM 8/5 1944, and that I last saw her alive on 8/5 1944.

Immediate cause of death	Duration
Intracranial hemorrhage?	1 da
Due to Birth Injury ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Nothing found - brain not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Felix Keerledge M. D.
Address Women's Hospital Date signed 8/4/44

G19656

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G19656

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be accurately supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] Orchard [illegible]
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Butler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bell
13. Birthplace Md.

MOTHER
14. Maiden Name Turner
15. Birthplace Md.

16 (a) Informant James R. Butler
(b) Address Dayton, Ohio

17 (a) Burial (b) Date thereof 8/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Waldorf, Md.
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill

19 (a) (Date received by Registrar) AUG 7 1944 (b) Filing Number [illegible] (c) [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1944, at 9A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Wollenweber, M.D.
Medical Examiner.
Date signed August 5 1944

G19657

YA-80546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19657 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr., 4 mos. 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 Woodyear St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1925

8. AGE: Years	Months	Days	If less than one day
18	9	28	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Delivery Boy

11. Industry or business

FATHER
12. Name Walter Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Julia Smith
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Anne Arundel Co. Md.

18 (a) Funeral director Wm. J. Chatman Jr
(b) Address 600 Pleasant St. City

19 (a) (Date received by registrar) AUG 7 1944 (b) Registrar's signature Washington Millender, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4/44 19 . at 8:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/14/43 19 , to 8/4/44 19 , and that I last saw him alive on 8/4/44 19 .

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Chronic pulmonary T.B.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Shea Haller M. D.

Address BCH Date signed 8/5/44

G19658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46F

G19658 Registered No.

MARGIN RESERVED. FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23rd & Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 56 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. or location 100 Upland Rd Roland Park Apts
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. [redacted] Keech (Caroline Virginia Pagon Keech)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, (widowed) or divorced.
6 (b) Name of husband or wife: Edward Parkin Keech
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 17, 1874
8. AGE: Years 69 | Months 10 | Days 19 | If less than one day ..... hr. ..... min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. William H. Pagon
13. Birthplace Maryland

MOTHER
14. Maiden Name Caroline Harper [redacted]
15. Birthplace Maryland Pattison

16 (a) Informant Administrator Mr. R.S. Pagon
(b) Address 209 Ridgewood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 E. [redacted] St.

19 (a) (Date received by registrar) AUG 7 - 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944 to Aug 6 1944, and that I last saw her alive on 8-6 1944.

Immediate cause of death Cardio Resp. Failure — Duration

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 7-6-44
Major findings of operation: Ca of gall bladder & Metastasis.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack C. Morgan M.D.
Address Union Memorial Hosp. Signed 8-6-44

G19659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G19659

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2726 Alameda Blvd.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 T
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Alameda Blvd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lena C. Klein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Charles F. Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1869

8. AGE: Years	Months	Days	If less than one day
75	6	11	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name John Voigel
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace Germany

16 (a) Informant George P. Klein
(b) Address 66 Broadship Rd., Dundalk, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery ~~Crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mikkelsen Sons, Inc.
(b) Address 1900 Eutaw Place

AUG 7 - 1944 Huntington Williams, M.D.
Date rec'd by Local Registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 4 1944, at 9.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1944 to Aug 4 1944 and that I last saw her alive on Aug 4 1944

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter A Anderson M. D.
Address 3801 Date signed 8/7/44

G19660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G19660

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 827 China Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olivia Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 1 | Months | Days | If less than one day: hr. min.

9. Birthplace: Chester, Pa.
(Town, county, and state)

10. Usual Occupation: —

11. Industry or business

FATHER
12. Name: Herman Ross
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Bessie Fuld
15. Birthplace: Md.

16 (a) Informant: Bessie Ross
(b) Address: 827 China St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location: A. A. Co. Md

18 (a) Funeral director: Isaiah L. Brown & Son
(b) Address: 108 W Montgomery St

19 (a) (Date received by Registrar) AUG 7 1944 (b) Washington, Maryland

VS 151

MEDICAL CERTIFICATION 40

20. DATE OF DEATH August 5, 1944, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Pneumonia, bronchial

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: H. L. Wallenstein M.D.
Asst. Medical Examiner.

Date signed 8-4-44

G19661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19661 Registered No. 13/a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1317 N. Patterson Pk. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 N. Patterson Pk Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ella L. Watts

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8 1862

8. AGE: Years 82 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER: 12. Name Robert Watts
13. Birthplace Pikesville Md.

MOTHER: 14. Maiden Name Gwendolyn Taylor
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Ella Moorehouse
(b) Address 1317 N. Patterson Pk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-7-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location North Ave

18 (a) Funeral director Wm. C. Miller Inc
(b) Address 2425 E. Oliver St

19 AUG 7 - 1944 (Date rec'd by reg.) Washington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 3 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Aug 3 1944 and that I last saw h[illegible] alive on Aug 3 1944

Immediate cause of death: Uremia — Duration: 3 day

Due to: Bacdes vascular renal disease — 6 mo

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. Mikesell
Address 2470 Madison Blvd Date signed Aug 4 1944 M. D.

G19662

JO #9281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19662 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs 25 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 421 S. Lehigh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Dacan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Samuel Dacan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1880

8. AGE: Years	Months	Days	If less than one day
64	-0-	-4-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Parrish
13. Birthplace Maryland

MOTHER
14. Maiden Name Unable to obtain infor-
15. Birthplace mation.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Brooklyn Balto. Maryland

18 (a) Funeral director Gilbert L. Hilliard
(b) Address 1606 N. Chester St.

19 (a) (Date rec'd by Reg.) (b) Huntington for Milhauser, Mgr. Registrar

AUG 7 1944 No

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1944, at 3:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1944 to 8/5 1944, and that I last saw h[illegible] alive on 8/5 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	12 hrs.
Cong. heart failure	?
Due to Hypertensive	?
cardiovascular disease	
Due to	
Other Conditions Peripheral edema	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above - but no gross evidence of cerebral hemorrhage.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Flora Holly

Address Balt Date signed 8/5/44 (M. D.)

G19663

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G19663 Registered No.

CERTIFICATE OF DEATH 136a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Colvert & Saratoga
(c) Hospital or institution: Mercy Hosp 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27d
(e) Length of stay in Baltimore (yrs., mos., or days) 43yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 365 Helen Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde Phillips

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-6525

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. X7

6 (b) Name of husband or wife Ruby

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5th 1900

8. AGE: Years 43 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name John Phillips
13. Birthplace Md

MOTHER 14. Maiden Name Clara Wilson
15. Birthplace Md

16 (a) Informant Pt.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7th 1944 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md Balto Co

18 (a) Funeral director Byron Thomas J. B. King
(b) Address 121 Dugan Ave

19 (a) (Date rec'd by registrar) (b) Huntington Md

VS AUG 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1944 at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1944 to Aug 4 1944, and that I last saw h. m. alive on Aug 4 1944.

Immediate cause of death Pulmonary embolism ?

Duration

Due to Thrombophlebitis

Due to Urinary extravasation with infection

Other Conditions Stricture of urethra

(Include pregnancy within 3 months of death)

Date of operation 7/31/44

Major findings of operation: Urinary extravasation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Smythe

Address Mercy Hosp Date signed 8/7/44

G19664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19664 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 501 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 501 E. Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Evangelista Gross O.S.P.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 15-1864

8. AGE: Years	Months	Days	If less than one day
80	4	29	hr. min.

9. Birthplace HUGUESVILLE, CHARLES CO., MD.
(Town, county, and state)

10. Usual Occupation RELIGIOUS

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant MOTHER M. TERESA
(b) Address 501 E. CHASE ST.

17 (a) BURIAL (b) Date thereof Aug 8, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location FREDERICK RD.

18 (a) Funeral director Mrs. Rose A. Elliott
(b) Address 1179 N. Caroline St.

19 (a) AUG 7 1944 Huntington Williams
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1944 at M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic
Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gretsch M.D.
Medical Examiner.
Date signed August 4 1944

Med Exam Case

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~G19665~~ X G19665 Registered No. 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Bengies (If outside city or town limits, write RURAL and give town)
(d) Street No. Bengies Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	married

6 (b) Name of husband or wife Viola Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-3-1891

8. AGE: Years	Months	Days	If less than one day
53	5		hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Glen L Martin

FATHER
12. Name Nelson Smith
13. Birthplace Va.

MOTHER
14. Maiden Name Mary ?
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. L.D. Elliott & Daughter
(b) Address 1129 N. Caroline St. Huntingtown Williams, Md.

19 (a) AUG 7 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION 40

20. DATE OF DEATH Aug 6 1944, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1944 to Aug 6 1944, and that I last saw h in alive on Aug 6 1944.

Immediate cause of death	Duration
Spontaneous cerebro-vascular accident	3 hours
Due to Hypertension	
Due to ? Renal disease (history) ?	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature T. S. Perrin

Address Johns Hopkins Hosp Date signed 8/6/44 M.D.

Approved: Robert L. Graham M.D. 8/7/44

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19666
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 138 S. Potomac St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 138 S. Potomac St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Elizabeth Luty.
3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1874

8. AGE: Years 69 70 | Months 10 | Days 87 | less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business —

FATHER 12. Name Charles F. Luty
13. Birthplace Germany.

MOTHER 14. Maiden Name Frederieka Bleich
15. Birthplace Germany.

16 (a) Informant George P. Mech
(b) Address 138 S. Potomac St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Matthews
Location 6104 O'Donnell St.

18 (a) Funeral director S. Walter May.
(b) Address 619 N. Bouldin St.

19 (a) (Date rec'd by registrar) (b) Huntington Mills, Md. (Registrar)

AUG 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944, to Aug 5 1944 and that I last saw h[er] alive on Aug 5 1944

Immediate cause of death	Duration
Coronary Thrombosis	Aug 4. 44
Due to Ch Myocard Dis	1/1/44
Due to Arterio-Sclerosis	1940
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Reynolds M.D.
Address 801 N. Eutaw St Date signed Aug 7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write

G19667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19667 Registered No.

1117a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 11 ys

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Bradford St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Louck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Barbara Louck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 1869

8. AGE: Years	Months	Days	If less than one day
75 yrs.	2	26	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Insurance Agent.

11. Industry or business

FATHER
12. Name Ludwig Louck
13. Birthplace unknown

MOTHER
14. Maiden Name Peters
15. Birthplace unknown

16 (a) Informant Barbara Louck
(b) Address 1722 Bradford St. Balto 13 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/7/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by Registrar) AUG 7 1944 (b) Huntingtown Md.

VS 128

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/3 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1944, to 8/3 1944, and that I last saw h[illegible] alive on 8/3 1944

Immediate cause of death Septic ulcer Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers, M.D.
Address Md. Gen. Hosp. Date signed 8/3/44

G19668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19668

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 713 South Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Korman--or--Frank Szczegelski

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-6146

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1900

8. AGE: Years 45 | Months 7 | Days 8 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name George
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 6/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Baltimore

18 (a) Funeral director Fred W Ozazgurski
(b) Address 1930 Eastern Ave.

19 AUG 7 1944 (b) Huntington Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 5, 1944 19..., at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22/44 19... to 8/5/44 19..., and that I last saw him alive on 8/5/44 19...

Immediate cause of death: Pulmonary Tuberculosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. E. Perry, Jr. M. D.
Address City Hosp. Date signed 8-7

G19669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 744

Registered No. G19669

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4408 Forrest View Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Forrest View Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Pocock

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-8478

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Clemmie Pocock
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Dec 10 1868

8. AGE: Years	Months	Days	If less than one day
55 07	7	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Stay Clerk
11. Industry or business American Can Co

FATHER
12. Name Charles E Pocock
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna C Voelker
15. Birthplace Germany

16 (a) Informant Mrs Clemmie Pocock
(b) Address 4408 Forrest View

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9th (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Beech

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Orleans St

19 (Signature of local registrar) AUG 7 - 1944 Huntington Maryland, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1944 at 630 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1943 to Aug 5 1944 and that I last saw h[illegible] alive on Aug 5 1944

Immediate cause of death — Duration

Chronic myelocytic leukemia — 4 yrs
Due to
Due to
Other Conditions Acute pulmonary edema — 1 day
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Lee Shelton
Address 4116 Northern Pkwy Date signed 8/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G19670

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2408 Orleans
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2408 Orleans
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Dieter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 26, 1887

8. AGE: Years: 57 Months: 6 Days: 10 If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Restauranter

11. Industry or business

FATHER
12. Name: Charles Dieter
13. Birthplace: M d.

MOTHER
14. Maiden Name: Ma ry Smith
15. Birthplace: Md.

16 (a) Informant: Ann a M. Dieter
(b) Address: 2408 Orleans

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Baltimore County

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2008 Orleans Street

19 (a) AUG 7 - 1944 (Date rec'd by registrar) (b) Huntington Millemann M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: A ugust 6, 19 44, at 8:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 19 44 to Aug 6 19 44 and that I last saw h[illegible] alive on Aug 6 19 44

Immediate cause of death: Cerebral Embolism — Duration: 1 day

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Blackman M. D.
Address 3[illegible] Date signed 8/8/44

A. J. Blackman 8/8/44

G19671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G19671 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (3)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 Bell Av.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Richard Neal.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace South Bell. Gen. Hospital (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Russell Neal
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Elizabeth Neal
15. Birthplace Baltimore, Md.

16 (a) Informant Hosp Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7th 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Baltimore
18 (a) Funeral director Charles F. Dell
(b) Address 15 [illegible]
19 (a) [illegible] (b) [illegible] (registrar) [illegible] Registrar

AUG 7 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1944 at 8 22 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1944 to Aug. 6 1944, and that I last saw h.. alive on Aug. 6 1944.

Immediate cause of death Prematurity — Duration 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul A. Lukats
Address 1213 Light St. Date signed M. 9 D. 7/44

G19672

G19672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 N. Rose St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country HANNAH.

3 (a) FULL NAME JOSEPH VINCENT HANNAH

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name Joseph V. Hannon
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret Marguardt
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Margaret Hannon
(b) Address 207 N. Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-44 (month) (day) (year)
(c) Cemetery or crematory Trinity Cemetery
Location O'Donnell St

18 (a) Funeral director L. J. Rueck
(b) Address 5305 Harford Rd.

AUG 7 1944
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V8 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature H. J. Wollenweber M.D. Medical Examiner.
Date signed 8-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TO BE APPROVED BY MEDICAL EXAMINER

G19673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 12213

G19673

YA-89264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
Dead on arrival
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Calhoun Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Mary Augustus Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
73?	?	?	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Robber
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Cinthia
15. Birthplace ?

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORD)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 7 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1944, at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944 to July 4 1944, and that I last saw him alive on July 4 1944

Immediate cause of death Strangulated Obstruction — Duration

Due to Undetermined cause

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature D. M. Phillippi M.D.
Date signed 8-5-44

Wm. E. Wallenmeyer M.D. Assistant Supervisor

G19674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1702

G19674 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Viola Ford Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19. 1939

8. AGE: Years	Months	Days	If less than one day
4	8	14	hr. min.

9. Birthplace Balto md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Mitchell
13. Birthplace

MOTHER
14. Maiden Name Margaret Ford
15. Birthplace Balto

16 (a) Informant Mat Geart Mitchell
(b) Address 702 W Mulberry St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Lotie R Williams
(b) Address 1702 Pennsylvania Ave

19 (a) AUG 7 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage of Brain

Due to Acute pulmonary edema

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ causes of death, fill in the following:
(a) Date of injury 8/3/44 at 10:40 A. M.
(b) Where did injury occur? Mulberry west of Myrtle Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed August 3 1944

G19675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G19675 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 N Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N Carey St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula C. Davis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow Dalls

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14 1894

8. AGE: Years 50 | Months 7 | Days 20 | If less than one day hr. min.

9. Birthplace Rodues N. C. (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Boone
13. Birthplace Roduce N. C.

MOTHER
14. Maiden Name Elberta Batchelor
15. Birthplace Roduce N. C. North Carolina

16 (a) Informant Charles Boone
(b) Address 2526 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Elizabeth City, N. C.
Location N. C.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date received by registrar) AUG 7 - 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944 to Aug 4 1944 and that I last saw h[illegible] alive on 8/4 1944

Immediate cause of death: Hypertensive Cardio-Renal

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature B. F. Stafford M. D.
Address 1715 Park Date signed 8/7/44

Huntington Williams, M.D.

G19676

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V56E

Registered No. G19676

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 5/27/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 5/26/44

2. USUAL RESIDENCE OF DECEASED:
(a) State None / in U.S. (b) County
(c) City or town (Randears, Denmark)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Denmark
(Add in U.S.A.: c/o Standard Oil Co. of N.J., Bayonne, N.J.)

3 (a) FULL NAME MARIUS LAURSEN

3 (b) If veteran, name war --

3 (c) Social Security Account No. -

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1891

8. AGE: Years 53 | Months 5 | Days 10 28 | If less than one day hr. min.

9. Birthplace Randears, Denmark (Town, county, and state)

10. Usual Occupation AB Seaman

11. Industry or business Standard Oil Co.

FATHER
12. Name Rasmus Laursen
13. Birthplace Randears, Denmark

MOTHER
14. Maiden Name Anna Petersen
15. Birthplace Randears, Denmark

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) B (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Cedar Lyn
18 (a) Funeral director James H. McCauley
(b) Address 1316 E. Fort Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH August 5, 1944, at 11:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 27, 1944, to Aug. 5, 1944, and that I last saw h im alive on Aug. 5, 1944

Immediate cause of death Large chondroma involving most of cervical vertebrae posteriorly with pressure on the spinal cord resulting in complete degeneration and necrosis in the mid & lower cervical region. Marked degeneration of the liver and fatty metamorphasis.

Duration: Has had pain in past yr. & 9 mos.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7/28-Cervical laminectomy

Major findings of operation: Portion of tumor was removed relieving all pressure from cervical cord.

If of autopsy: As above

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Accum M. D.

Address Baltimore, Md. Date signed 8/7/44

FS-53227

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G19677

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) bm.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 549 E 38th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NICHOLAS-JAMES-MURPHY

3 (b) If veteran, name war	3 (c) Social Security Account No. 214-03-2957

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Catherine Hartline
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) Nov 17. 1892

8. AGE: Years	Months	Days	If less than one day
51	8	19	....hr. ....min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Grain Feeds + Seed

FATHER
12. Name Nicholas Murphy
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Mc Enaney
15. Birthplace Ireland

16 (a) Informant Mrs. Catherine Murphy
(b) Address 549 E. 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md

18 (a) Funeral director Henry Sanders & Sons
(b) Address North Ave + Broadway

19 (a) AUG 7 1944 (b) Huntington Ave Baltimore, Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5, 1944 at 12 50 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. H. Wallenmeyer M.D. Medical Examiner.
Date signed 8-6-44

G19678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19678 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Station Hospital Holabird Signal Depot, Balto. 19, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

9/9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 E. Lanvale St.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Knieling, Anna T.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife J. Louis Knieling
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1885

8. AGE: Years	Months	Days	If less than one day
58	10	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Post Exchange-Camp Holabird

FATHER
12. Name Henry Thielemann
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Potter
15. Birthplace Germany

16 (a) Informant Mr. Henry Thielemann
(b) Address 6004 Belair Rd. 6

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 7 1944
(b) Date rec'd by reg. [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 5th August 1944, at 2:05PM

21. I certify that death occurred on the date above stated; that I attended deceased from 27 July 1944, to 5 Aug 1944, and that I last saw her alive on 5 Aug 1944

Immediate cause of death	Duration
Spontaneous subarachnoid hemorrhage	10 das
Due to Unknown	
Due to Unknown	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Capt. Short M.C.
Station Hospital
Address Holabird Signal Depot M. D.
Date signed 5 Aug 44

G19679

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G19679 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dor
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3445 Greenmount (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Gordon-Lee Griffith, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 23, 1943

8. AGE: Years	Months	Days	If less than one day
1	0	12	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Gordon Lee Griffith Sr.
13. Birthplace Johnstown, Pa.

MOTHER
14. Maiden Name Dolores Forbritton
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Griffith
(b) Address 3048 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Balto., Md.

18 (a) Funeral director Wm. J. Tschiener & Sons
(b) Address [illegible] Md.

19 (a) [illegible] (Inserted by registrar) (b) Hartman Funeral Home, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1944 at 7P. M

21. I certify that I took charge of the remains described above, held an ..... thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-5-44 at 12/2 M.
(b) Where did injury occur? Chesapeake Bay
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? .....
(d) Means of injury drowned in tub

23. Signature H. L. Wallenmeyer M.D. Asst Medical Examiner.
Date signed 8-6-44

G19680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19680
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 S. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 S. Gilmor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA M. GERMERSHAUSER

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frank J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1875

8. AGE: Years	Months	Days	If less than one day
68	10	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Frederick List
13. Birthplace Utica, N. Y.

MOTHER
14. Maiden Name Mary Schum
15. Birthplace N. Y.

16 (a) Informant Mr. Frank Germershauser
(b) Address 234 S. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

19 (a) AUG 7 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5, 1944, at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to Aug 5 1944 and that I last saw him alive on Aug 2 1944

Immediate cause of death: Carcinoma Body of uterus — Duration 6 mo.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. McCallum M.D.
Address 3321 Fred. Ave. Date signed 8-6-44 M. D.

G19681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G19681
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Sulgrave Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Sulgrave Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Rich.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Philip L. Rich.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29 1879

8. AGE: Years	Months	Days	If less than one day
65	6	7	hr. min.

9. Birthplace North Carolina.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Jerusha A. Kendall.
15. Birthplace N. C.

16 (a) Informant Myrtle E. Hartzell.
(b) Address 1615 Sulgrave Ave.

17 (a) Burial (b) Date thereof Aug 9/944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn.
Location Woodlawn Md.

18 (a) Funeral director Bridgewater & Donovan.
(b) Address 1401-11 Eastern Ave.

19 (a) (b)
(Date received) (Registrar)

AUG 7 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944, at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Aug 6 1944.
and that I last saw her alive on Aug 6 1944.

Immediate cause of death	Duration
Coronary Thrombosis	24 hrs.
Due to Hypertensive C V D.	?
Due to	
Other Conditions Pernicious Anemia	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence J. Shimanek M.D.
Address 3744 Dalrymple Date signed 8-9-44
Laurence J. SHIMANEK

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19682 / 32 / G19682

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522 E. Gold Spring Lane.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 522 E. Gold Spring Lane. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida V. Pahlman.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George H. Pahlman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1872

8. AGE: Years	Months	Days	If less than one day
71	11	-	hr. min.

9. Birthplace Md. (Town, county and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name George Schwartz.
13. Birthplace Md

MOTHER
14. Maiden Name Susan Frank.
15. Birthplace Md

16 (a) Informant Marion H. Johnson.
(b) Address 522 E. Gold Spring Lane.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8, 1944 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Hemmeter & Donovan.
(b) Address 345-17 Aberdeen Ave.

19 (a) AUG 7 - 1944 (Registrar) Huntington Woods, Md. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944, at 2:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1934, to Aug 6 1944, and that I last saw h[illegible] alive on Aug 6 1944

Immediate cause of death

Coronary Occlusion

Due to Chronic Myocarditis + Generalized Arteriosclerosis

Due to + hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 hours.
10 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence At M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis J. Lynch M.D.

Address 2005 Eutaw Pl. Date signed 8/7/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19683 (Registered No.)

G19683

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga Ave & Dukeland St.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County Baltimore
(c) City or town Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 7915 Oakedale Rd (if rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Paul H. Dawson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 234-07-6345

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alma M
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Aug 20 1886

8. AGE: Years	Months	Days	If less than one day
57	11	15	..... hr. ..... min.

9. Birthplace Portsmouth Ohio (Town, county, and state)
10. Usual Occupation Die Maker
11. Industry or business Foreman Rust Iron & Steel

FATHER
12. Name James Dawson
13. Birthplace Ohio

MOTHER
14. Maiden Name Elizabeth Woods
15. Birthplace Ohio

16 (a) Informant Mrs Alma M. Dawson
(b) Address 7915 Oakedale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location

18 (a) Funeral director Leonard S. Ruck
(b) Address 3-5 Harford Rd.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1944 to 8/5 1944 and that I last saw h. alive on 8/5 1944

Immediate cause of death	Duration
Coronary artery Disease	
Coronary Thrombosis	1 day
Due to Basal CVD	
Due to	
Other Condition Congenital Syphilis	6 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Taylor
Address W.B.G.H. Date signed M. 8/5 D. /44

G19684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 121

G19684 Registered No.

RESERVED FOR HEADING

MAROON INK. Every item of information should be carefully supplied. The PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2919 Joppa Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma E. Marsh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles W.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) May 22 1883

8. AGE: Years	Months	Days	If less than one day
61	2	7	..... hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Frederick Crowley
13. Birthplace N.Y.

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md.

16 (a) Informant Mr. Charles W. Marsh
(b) Address 2919 Joppa Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-44 (month) (day) (year)
(c) Cemetery or crematory Radimoor
Location

18 (a) Funeral director L. J. Rusk
(b) Address 530 Harford Rd.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3 1944, to 8-6 1944, and that I last saw h or alive on 8-6 1944.

Immediate cause of death Pulmonary Embolus
(Post Operative)
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 8-3-44
Major findings of operation: Acute Appendicitis
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Stanley B. Klyanowicz M.D.
Address St. Joseph's Hosp. Date signed 8/8/44

G19685 G19685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 909 DeSoto Rd. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Hargest

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Mrs. Blanche Hargest

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 23, 1878

8. AGE: Years 66 | Months 3 | Days 12 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Edw. W. Hargest
13. Birthplace Balto.

MOTHER 14. Maiden Name Mary King
15. Birthplace Balto.

16 (a) Informant Mercy Hospital
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick ave

18 (a) Funeral director Henry Lutz
(b) Address 1203 N. Broadway

19 (a) (Date received by registrar) (b) Baltimore, Md.

AUG 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1944 at 6:20 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/22 1944 to 8/5 1944; and that I last saw him alive on 8/5 1944.

Immediate cause of death Card. Failure — Duration

Due to Coronary Thrombosis — 2 wks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. H. Crosby
Address Mercy Hospital Date signed 8/5

G19686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G19686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 N. Pine St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 N. Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife James H. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr) May 26, 1874

8. AGE: Years 70 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Marshall Thomas
13. Birthplace Md.

MOTHER
14. Maiden Name Louisa Cassell
15. Birthplace Md

16 (a) Informant Lillie Brown Bryan
(b) Address 922 N. Pine St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bentley ave

AUG 7 - 1944
(Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944, at 2:37 PM

21. I certify that death occurred on the date above stated, that I attended deceased from July 22 1944 to Aug 6 1944
and that I last saw h[illegible] alive on Aug 6 19 44
Immediate cause of death

	Duration
Due to Arteriosclerosis and Valvular disease	2 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 75 Woodyard Date signed 8/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19687 — BALTIMORE CITY HEALTH DEPARTMENT — G19687

CERTIFICATE OF DEATH

149B — Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1121 W. Balto. St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Frances Dailey — 30576

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anthony J Dailey

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) July 22, 1917 ~~July 22, 1916~~

8. AGE: Years 27 ~~26~~ | Months - | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name John Reddington

13. Birthplace Baltimore Md.

MOTHER — 14. Maiden Name Flora Durst

15. Birthplace Baltimore.

16 (a) Informant Anthony Dailey

(b) Address 1121 W. Balto St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8, 1944 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cemetery

Location Baltimore, Md.

18 (a) Funeral director Wells Donovan

(b) Address 1005 W. Baltimore St.

19. (a) ____ (Registrar) (b) Huntington Williams M.D.

AUG 7 1944

AUG 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1944 at 4 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1944 to Aug 5 1944 and that I last saw h[illegible] alive on Aug 5 1944

Immediate cause of death: Cardiac Failure — Duration

Due to: Cerebral Embolus

Due to: Post operative Cesarean Section

Other Conditions: acute distention of the abdomen.
(Include pregnancy within 3 months of death)

Date of operation July 31, 1944

Major findings of operation: Full Term Pregnancy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. C. English M. D.

Address Mercy Hospital Date signed 8/5/44

G19688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19688 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Burleith Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Chesler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: late Sarah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 1 1877

8. AGE: Years 66 | Months 10 | Days 6 | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business: Retired

FATHER — 12. Name: Israel Chesler
13. Birthplace: Russia

MOTHER — 14. Maiden Name: Sarah ?
15. Birthplace: Russia

16 (a) Informant: Reuben M Chesler
(b) Address: 3309 Burleith Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug, 8, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Washington Road
Location: Washington Blvd

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

AUG 7-1944 (Date rec'd by registrar) Huntington Williams, M.D.

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7-44 1944, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1944, to 8-7 1944, and that I last saw him alive on 8-7 1944.

Immediate cause of death: Coronarie heart failure i pedemonary a degree — Duration

Due to: hypocardid infarction

Due to: Coronary occlusion

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Myron J. Myers M. D.
Address: Sinai Hospital Date signed 8-7-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

248475

G19689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 99

G19689

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County B.A. Co.
(c) City or town Comberatown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Tongue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Mal	Black	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-09

8. AGE: Years	Months	Days	If less than one day
35	2	25	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Eli Tongue

13. Birthplace Md.

14. Maiden Name Elizabeth Johnson

15. Birthplace Md.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/9/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Chews

Location West River, Md

18 (a) Funeral director T. A. Hardesty & Son

(b) Address Galesville, Md.

AUG 9 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1944 at 7 25 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to Aug 7 1944 and that I last saw him alive on Aug 7 1944

Immediate cause of death Peritonitis nodosa — Duration 6 weeks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Gamerman

Address J H Hospital Date signed 8-7-44

G19690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19690

Registered No. 1046

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 165 E. Fort Ave. (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Mary Jane Haslup.
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan. 1 - 1936
8. AGE: Years 8 | Months 7 | Days 5 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation at School
11. Industry or business

FATHER
12. Name Frederick Haslup
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Alice A. Mitchell
15. Birthplace Balto, Md.

16 (a) Informant Mrs Mary Jane Haslup
(b) Address 167 Fort Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Park
Location Balto
18 (a) Funeral director Edward Evans
(b) Address 1400 Abbott St
19 (a) Aug 1944 (b) Filed by registrar [illegible]

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944, at 12 40 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1944 to Aug. 6 1944 and that I last saw h e alive on Aug. 6 1944.
Immediate cause of death Cerebral hemorrhage

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Carl H. Lukats
Address 1213 Light St. Date signed M. 8 D. 6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 f

Registered No. G19691

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Lombard + Greene Sts.

(c) Hospital or institution: University Hospital 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days

(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Prince George's

(c) City or town Laurel (If outside city or town limits, write RURAL and give town)

(d) Street No. 310 Laurel Ave. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Osborn Vickers

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1912

8. AGE: Years 31 | Months 9 | Days 22 | If less than one day — hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business Law

FATHER 12. Name Arthur L. Vickers

13. Birthplace Md.

MOTHER 14. Maiden Name Beatrice Osborn

15. Birthplace Ohio

16 (a) Informant Mrs. Beatrice Vickers

(b) Address Laurel, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)

(c) Cemetery or crematory Lawndon Park

Location Balto. Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St Paul St

AUG 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7 1944 at 3:08 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/23 1944 to 8/7 1944, and that I last saw h.i.m alive on 8/7 1944

Immediate cause of death: Resp. failure — Duration 3 hrs

Due to: Hodgkin's disease — 2 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —

(e) Means of injury —

23. Signature Alfred I Nelson M. D.

Address University Hospital Date signed 8/7/44

G19692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19692 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1513 N Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1513 N Wolfe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Pegelow
3 (b) If veteran, name war no
3 (c) Social Security Account No. None
4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 29 1883
8. AGE: Years 60 | Months 10 | Days 10 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name George Pegelow
13. Birthplace Sweden
14. Maiden Name Christina Haglmon
15. Birthplace Baltimore Md

16 (a) Informant Tina L Spillman
(b) Address 1513 N Wolfe St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md
18 (a) Funeral director Wellborn Cook Inc
(b) Address 1217 St Paul St

AUG 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944 at 9:45 M
21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1944 to 8/6 1944 and that I last saw him alive on 8/6 1944.

Immediate cause of death: Chronic Interstitial nephritis — Duration 3 yrs
Due to:
Due to:
Other Conditions: Hypertension degeneration — Duration 6 days
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature David Miller
Address 1500 N Broadway Date signed 8/8/44 M.D.

G 19693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G-19693

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 191 Gittings Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia K. Nighan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph Nighan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1906

8. AGE: Years	Months	Days	If less than one day
37	9	26	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Harry Campbell & Co.

FATHER
12. Name James H. O'Brien
13. Birthplace Laurel Md.

MOTHER
14. Maiden Name Josephine Vogt
15. Birthplace Laurel Md.

16 (a) Informant Josephine O'Brien
(b) Address 19 Gittings Avenue

17 (a) Burial (b) Date thereof 8/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 AUG 8 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1944, at 10 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Homicide.
(a) Bullet wound of head.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-6-44 at 7:15 A. M.
(b) Where did injury occur Woodbourne Ave & Pilen Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public pl. While at work? No.
(d) Means of injury Rifle Bullet.

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed August 10, 1944

G19694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G19694 Registered No.

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) ~~Hospital or~~ institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5213 Craig Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Virginia E. Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married, widowed, or~~ divorced.
Female	White	Divorced

6 (b) Name of husband Duncan Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 29th 1889

8. AGE: Years	Months	Days	If less than one day: hr.	min.
45	3	6	9	1849

9. Birthplace Easton Pa. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Social Security Board

FATHER
12. Name Edward L Mitchell
13. Birthplace Unknown

MOTHER
14. Maiden Name Eliza Covell
15. Birthplace Un Known

16 (a) Informant Duncan Miller
(b) Address 5213 Craig Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by registrar AUG 8 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6th 1944, at Millard M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944 to Aug 6 1944, and that I last saw ~~him~~ her alive on Aug 6 1944

Immediate cause of death	Duration
(a) Pneumonia	2 days
Due to (b) Coronary Thrombosis	1 day
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury

23. Signature [illegible]
Address 112 W. 25th St Date signed Aug 6, 44

VS 150

G19695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 ✓

Registered No. G19695

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5313 Reisterstown Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert S. Gallagher

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-0079

4. Sex	5. Color or race	6 (d) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Alma C. Gallagher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15th 1897

8. AGE: Years	Months	Days	If less than one day
47	2	20	hr. min.

9. Birthplace Hagerstown, Md.
(Town, county, and state)
10. Usual Occupation Industrial Engineer
11. Industry or business William Wilkens Co

FATHER
12. Name James Gallagher
13. Birthplace Kentucky

MOTHER
14. Maiden Name Cora Bender
15. Birthplace Nebraska

16 (a) Informant Mrs Alma Gallagher
(b) Address 5313 Reisterstown Rd

17 (a) Burial (b) Date thereof 8/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

AUG 8 - 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1944 at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1932 to Aug 5 1944, and that I last saw h~~im~~er alive on Aug 1 1944

Immediate cause of death Coronary occlusion.

Duration

Due to arterio-sclerosis & hypertension

Due to

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dolph Street

Address 712 Park Ave Date signed Aug 8 1944
M. D.

G19696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G19696

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 N. Caroline St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-1

(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josiah Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	Widower

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1885

8. AGE: Years	Months	Days	If less than one day
59	2	7	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Va 3

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Alice Greenwood
(b) Address 626 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson

19 AUG 8 - 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5-1944, at 11.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15 1944, to 1944, and that I last saw h.im alive on 19.

Immediate cause of death Cardio Renal Disease — Duration —

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Rogers M. D.
Address 611 N. Carey Date signed 8-7-44

G19697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 457

G19697
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404 N.Carrollton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-2
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 N.Carrollton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Max Owens

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 215-07-7746

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Marie

6 (c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): 2/15/1908

8. AGE: Years: 36 | Months: 5 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual Occupation: Laberer

11. Industry or business

FATHER
12. Name: William Owens
13. Birthplace: Va.

MOTHER
14. Maiden Name: Alice ?
15. Birthplace: Va.

16 (a) Informant: Marie Owens(Wife)
(b) Address: 404 N.Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion.
Location: Balto. County, Md.

18 (a) Funeral director: Charles H. Hooper
(b) Address: 512 N.Carrollton Ave

19 (a) Date received AUG 8 1944 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/4/1944 19 , at 10:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 19 44 to 8/4/44 19 44 and that I last saw h alive on 8/4/44 19 44

Immediate cause of death: Cardiac Failure

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration
1 Hr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: B. N. Hatcher M. D.

Address: 1 x x D e Date signed: 8/7/44

G19698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G19698 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 N. Charles
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 117 W. 29th St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Leonora Kate Doelle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Fem | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 02, 1882

8. AGE: Years 62 | Months 3 | Days 14 | If less than one day hr. min.

9. Birthplace Union Bridge Md. (Town, county, and state)

10. Usual Occupation Reg. nurse

11. Industry or business Johns Hopkins Hosp.

FATHER 12. Name John Wesley Doelle

13. Birthplace Freemount, Md.

MOTHER 14. Maiden Name Charlotte E. Flowers

15. Birthplace Manchester Md.

16 (a) Informant Husband

(b) Address 2020 N. Charles

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof August 8-1944 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944 at 10:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1944 to Aug 6 1944 and that I last saw h alive on Aug 5 1944

Immediate cause of death carcinoma of cervix | Duration 5 mo

Due to metastasis to liver and lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Mar. 1944

Major findings of operation: as above

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. G. Jones

Address 2818 Ft Davis Date signed 8/7/44 M. D.

Huntington Williams, M.D.

G19699

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

13 1a G19699 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 792 W. Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 910 Carlington Ave (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary Frances Mills

3 (b) If veteran, name war —

5 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Godfrey Mills

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Pitt Co North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Clifton W. Cox
13. Birthplace Pitt Co N. Carolina

MOTHER 14. Maiden Name Mary Cox
15. Birthplace Pitt Co N Carolina

16 (a) Informant Godfrey Mills Husband
(b) Address 910 Arlington Ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof Aug 8-1944 (month) (day) (year)
(c) Cemetery or crematory Rock Hill Mound
Location North Carolina

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (Date rec'd by Registrar) AUG 8 1944 (b) Burlington, Wis.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944 at 330a M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Aug 6 1944, and that I last saw h e alive on Aug 4 1944.

Immediate cause of death: Cardio-Vascular Renal Disease — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A P Hughes M D
Address 825 N Fremont Ave Date signed 8/6/1944

G19700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 V

G19700 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 130 N. Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 130 N. Linwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Bloom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jacob Bloom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Jacob Kassow

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Miriam -

MOTHER 15. Birthplace Russia

16 (a) Informant Minnie Paul

(b) Address 130 N. Linwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Isaac Levin Inc

(b) Address 1439 E. Balto St

AUG 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7 1944, at 3A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-10 1943, to 8-7-1944, and that I last saw h alive on 8-6 1944.

Immediate cause of death Carcinoma of Colon

Duration 1 yr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. J. Dandor M. D.

Address 3218 Eastern Ave Date signed 8-7-44

G19701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19701 Registered No.

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Groch (Groth)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widower

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years	Months	Days	If less than one day
81			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Gray
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary O'Brien
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 917 Drummond Ave

19 (a) (Date received) AUG 8 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION 24 m.

20. DATE OF DEATH August 6 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 5 1944, and that I last saw h[illegible] alive on Aug 5 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days
Due to: Chr Nephritis
Due to: Chr Myocarditis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Oscar F. Dukes M. D.
Address 928 E. North Ave Date signed 8/6/44

Huntington Williams, M.D.

G19702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G19702 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 Longwood Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 d 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 10 Longwood Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ELLA SAULSBURY FISHER

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Wm. Pliny Fisher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1867

8. AGE: Years	Months	Days	If less than one day
77	1	28	hr. min.

9. Birthplace: Caroline Co., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: June 9, 1867

FATHER
12. Name: Edward Saulsbury
13. Birthplace: Caroline Co., Md.

MOTHER
14. Maiden Name: Mary Jane Spurry
15. Birthplace: Caroline Co., Md.

16 (a) Informant: Mr. William J. Kindley
(b) Address: 10 Longwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)
(c) Cemetery or crematory: Denton Cem.
Location: Denton, Md.

18 (a) Funeral director: VIRGIL MOORE
(b) Address: Denton, Md.

19 (a) (b)
(Date received by registrar) Registrar
AUG 8 - 1944

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Aug. 7, 1944, at 10:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/26 1943, to 8/7 1944, and that I last saw her alive on 8/7 1944.

Immediate cause of death: Cerebral Vascular accident — Duration: 2 yrs
Due to: Arteriosclerosis — Duration: unknown
Due to:
Other Conditions: Bronchopneumonia — Duration: 3 days

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Francis W Gluck M.D.
Address 715 Park ave Date signed 8/9/44

G19703

T.G.P.-80099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46d

G19703 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Burgundy Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Grace

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 16,1884

8. AGE: Years	Months	Days	If less than one day
59	11	20	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Grace
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Rd

18 (a) Funeral director Edward Hayden
(b) Address 2309 W Baltimore Blvd

AUG 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1944 19 , at 5:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1944 to 8-6 1944, and that I last saw him alive on 8-6 1944.

Immediate cause of death	Duration
UREMIA	1 WK
Due to PYELONEPHRITIS	?
Due to CARCINOMA OF RECTUM WITH ERSION INTO BLADDER	?
Other Conditions HYPERTENSIVE CARDIO-VASCULAR DISEASE	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Wm Kenneth Smith M. D.
Address East. City Hospitals Date signed 8-6-44

G19704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 V

Registered No. G19704

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 North H.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD DENNIS MALONE

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace UNKNOWN (Town, county, and state)
10. Usual Occupation SEA MAN
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace ?

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace ?

16 (a) Informant CITY MOURGE
(b) Address 700 FLEET ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 8/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST. Hunting for Williams, M.D.

19 (a) AUG 8 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944 at 10 15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculosis pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.
Date signed 8-6-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

G19705 BALTIMORE CITY HEALTH DEPARTMENT ✓ G19705

CERTIFICATE OF DEATH 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2014 BANK ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2014 BANK ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ETHEL HELM

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife DAVID C.HELM
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG.10 1894

8. AGE: Years	Months	Days	If less than one day
49	11	27	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name HARRY BARROWS
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name ANNA SCHULOSER
15. Birthplace BALTO.MD.

16 (a) Informant DAVID C.HELM (HUSBAND)
(b) Address 2014 BANK ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG.10/44 (month) (day) (year)
(c) Cemetery or crematory OAKLAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly and Beiler INC.
(b) Address 407 S.WOLFE ST.

19 (a) AUG 8 1944 (Date rec'd by registrar) (b) Huntington Williamson, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG.7 1944, at 7.55 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Aug.7 1944, and that I last saw him alive on Aug.7 1944

Immediate cause of death: Uraemia — Duration 2 days

Due to: Chronic Nephritis & Hypertension? Valvular Heart Disease

Due to:

Other Conditions: Elephantiasis — Duration 5 yrs.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry Stemple M. D.
Address 200 E. Preston Date signed 8/8/44

G19706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

G19706

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Powell Orrick
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-30-29 1920

8. AGE: Years	Months	Days	If less than one day
24	4	7	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation none
11. Industry or business

MOTHER / FATHER
12. Name S. Hilton Orrick
13. Birthplace Md
14. Maiden Name Ellen Powell
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave
18 (a) Funeral director John O. McGuire & Sons, Inc.
(b) Address 1900 Eutaw Place
19 (a) AUG 8 - 1944 (Date Rec'd by Registrar) Registrar

VS 150

Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1944, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1944, to Aug 7 1944 and that I last saw him alive on Aug 7 1944

Immediate cause of death Unexplained fever — Duration

Due to Arteritis

Due to Pressure sores

Other Conditions Psychosis

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Langworthy
Address Johns Hopkins Hosp. Date signed 9/5/44

G19707 BALTIMORE CITY HEALTH DEPARTMENT G19707

CERTIFICATE OF DEATH 94a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2921 St. Paul St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, (If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Wm. Flack Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Eliz. Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1867

8. AGE: Years 77 | Months 3 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name James W. Flack
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Baker
15. Birthplace Balto. Md.

16 (a) Informant Mr. James W. Flack 3rd.
(b) Address 1119 Bellemore Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/8/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) AUG 8 - 1944 (Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1944 to Aug 6 1944, and that I last saw him alive on Aug 5 1944.

Immediate cause of death: Cerebral thrombosis — Duration: Few hrs.
Due to: arteriosclerosis — Duration: 1 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Hamilton Williams M.D.
Address 8 E. 39th. St. Date signed

Hamilton Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

327960 G19708

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19708
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Portsmouth (If outside city or town limits, write RURAL and give town)
(d) Street No. R.D.#3 Box-11-N. Geneva, Pk. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank E. Johnson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife HILYA JOHNSON
6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) 5-10-86

8. AGE: Years	Months	Days	If less than one day
58	2	26	hr. min.

9. Birthplace FINLAND (Town, county, and state)
10. Usual Occupation Carpenter foreman
11. Industry or business

MOTHER / FATHER
12. Name August Johnson
13. Birthplace Finland
14. Maiden Name MANDIE ?
15. Birthplace Finland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (b) Date thereof 8/9/44 (Burial, cremation, or removal) (month) (day) (year)
(c) ~~Cemetery or crematory~~ London Park
Location 3800 Frederick Ave.
18 (a) Funeral director
(b) Address AUG 1944 Baltimore Place
19 (a) (b) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944 at 2/A 50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1944 to Aug 6 1944 and that I last saw him alive on Aug 6 1944.

Immediate cause of death (Enter only one cause per line for (a), (b), and (c).) — Duration

(a) Interstitial Cystitis, Urinary Infection,
Due to Liver metastases.
Due to
Other Conditions

over

(Include pregnancy within 3 months of death)
Date of operation 7/29/44
Major findings of operation: Carcinoma of Cervix with
of autopsy Metastases to Liver.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leo W. Chambers M. D.
Address Johns Hopkins Hosp. Date signed 8/9/44

Huntington, Milwaukee, Wis

458585 G15709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55e

Registered No. G19709

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Florida (b) County.....

(c) City or town Orlando - (If outside city or town limits, write RURAL and give town)

(d) Street No. 829 Eaton Ave. (If rural give location)

(e) Citizen of foreign country?..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME Allen G. Tisdale -

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna M. -

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 3-27-01

8. AGE: Years 43 | Months 4 | Days 9 | If less than one day ..... hr. ..... min.

9. Birthplace Georgia - (town, county, and state)

10. Usual Occupation Bank Clerk -

11. Industry or business .....

FATHER: 12. Name J. E. Tisdale

13. Birthplace Ga.

MOTHER: 14. Maiden Name Sarah J. Allen

15. Birthplace Ga.

16 (a) Informant Riconde -

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)

(c) Cemetery or crematory .....

Location Orlando, Florida

18 (a) Funeral director C. O. Mitchell Funeral Home

(b) Address 1900 Central Ave

19 (a) ..... (Date rec'd by registrar) AUG 8 - 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 1944 at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1944 to Aug 6 1944 and that I last saw him alive on Aug 6, 1944

Immediate cause of death Cardiac failure — Duration .....

Due to Arteriosclerotic Heart Disease — Duration .....

Due to ..... — Duration .....

Other Conditions Malignancy involving Liver and Spleen. — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature Wm. A. Speed III

Address Johns Hopkins Hosp. Date signed 8-7-44 M. D.

G19710

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19710

59 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Fulford Ave.
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 18 S. Madeira St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Tate

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1944

8. AGE: Years	Months	Days	If less than one day
			3 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation newborn
11. Industry or business

FATHER
12. Name Frank Tate
13. Birthplace

MOTHER
14. Maiden Name Helen Bowers
15. Birthplace Baltimore, Md.

16 (a) Informant Helen Tate
(b) Address 18 S. Madeira St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Kendall & Hospel
(b) Address 315 S. Highland Ave
19 (a) (b) Huntington Williams, M.D. Registrar

VS-3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5, 1944 19 , at 4:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 19 44 to Aug 5 19 44 and that I last saw h alive on Aug 5 19 44
Immediate cause of death Premature

Duration

Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy: Premature

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Raymond B. Strelberg M.D.
Address Sinai Hosp. Date signed 8/6/44

G19711

T.C.P.-47585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 W

G19711 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs. 11 mos. 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 927 Lemmon Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Gange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1904

8. AGE: Years	Months	Days	If less than one day
40	6	23	hr. min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER
12. Name Frank Gange
13. Birthplace Italy

MOTHER
14. Maiden Name Lillian Perrica
15. Birthplace Italy

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director John J. Duda
(b) Address 2629 Hudson St

19 (a) Date rec'd Aug 8 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1944 19 , at 9:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14/39 19 to 8/6/44 19 , and that I last saw h[illegible] alive on 8/6/44 19 .

Immediate cause of death

Pulmonary Tuberculosis — Duration ?
Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Berry, M.D.
M. D.

Address City Hosp. Date signed 8-7

G19712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19712 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Rosalie Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Rosalie Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Anna Dittmar,

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jacob Dittmar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1869

8. AGE: Years	Months	Days	If less than one day
74	9	1	hr. min.

9. Birthplace: Baltimore City.
(Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business: at home

FATHER
12. Name: Valentine Hoffman,
13. Birthplace: unknown

MOTHER
14. Maiden Name: unknown
15. Birthplace: unknown

16 (a) Informant: Mrs. Edna M. Whaler,
(b) Address: 3116 Roalie Ave.,

17 (a) Burial (b) Date thereof 8/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore City,

18 (a) Funeral director: C. Vernon Lemmon
(b) Address: 4611 Park Heights Ave.,

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/25 1944 to 8/5 1944, and that I last saw her alive on Aug. 5, 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 1 week

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold A. Scott M. D.
Address 8100 Harford Road Date signed 8/7/44

G19713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G19713 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Wilkens Aves
(c) Hospital or institution: St. Agnes Hospital 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5106 Franklintown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry P. Failing

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	married

6 (b) Name of husband or wife Jennie S. Failing
6 (c) If alive, give age 77 yrs

7. Birth date of deceased (mo., day, yr.) Feb. 20. 1866

8. AGE: Years	Months	Days	If less than one day
78	5	17	hr. min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation Retired Painter
11. Industry or business

FATHER
12. Name Titus Peck Failing
13. Birthplace N.Y.

MOTHER
14. Maiden Name Phoebe Parsonson
15. Birthplace Utica N.Y.

16 (a) Informant Mrs. Jennie S. Failing
(b) Address 5106 Franklintown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn Md

18 (a) Funeral director D. Howard Strong
(b) Address 3707 W. North Ave.

19 (a) (b)

AUG 8 - 1944
Huntington, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6 1944, at 11:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1944 to 8-6 1944 and that I last saw him alive on 8-6-44 1944

Immediate cause of death Terminal Pneumonia
Following Cholecystectomy

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-2-44

Major findings of operation: Cholecystitis with cholelithiasis

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D.
M. D.

Address St Agnes Hosp Date signed 8-6-44

G19714

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19714 Registered No. 167

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 144 N. Dolphin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRED BENJAMIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25. 1911

8. AGE: Years 32 | Months 30 | Days 7 | If less than one day hr. min. 9

9. Birthplace Florence S. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Flemon Benjamin
13. Birthplace Florence S. C.

MOTHER
14. Maiden Name Rosilee Gaines
15. Birthplace Florence S. C.

16 (a) Informant Mrs. Sadie Thompsett
(b) Address 144 Dolphin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 1944 (month) (day) (year)

(c) Cemetery or crematory Florence
Location Florence S. C.

18 (a) Funeral director Wm. J. Chatman Jr.
(b) Address 6009 Priscott Ave.

19 (a) AUG 8 - 1944 (Date received by Registrar) Registrar, Baltimore, Md.

VS 151

Jerome McDaniel

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4, 1944, at 7 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Hemorrhage

Due to Multiple Stab wounds

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-4-44 at 6:15 P. M.
(b) Where did injury occur? 310 N. Biddle Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Stabbed

23. Signature Robert Lee Fraker M.D.
Medical Examiner.
Date signed Aug 5 1944

(OVER)

MARG... RESERVED FOR BI...ING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 139a

G19715 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1403 N. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara LEINE

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Daniel Leine
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years	Months	Days	If less than one day
74			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant H. Joseph's Hosp.
(b) Address 1400 N. Caroline St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-44 (month) (day) (year)
(c) Cemetery or crematory Mrs Catholic
Location Edmondson Ave
18 (a) Funeral director John J. Miller Inc.
(b) Address 243 E. Oliver St.
19 (a) Huntington Williams, Mgr (b) Registrar AUG 8 - 1944

VS 15

MEDICAL CERTIFICATION

P

20. DATE OF DEATH 8 - 6 1944, at 12:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 6 - 16 1944, to 8 - 6 1944, and that I last saw her alive on 8 - 6 1944.

Immediate cause of death: Myocardial failure — Duration: 49 da
Due to: Hypertensive cardio-vascular disease
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation 6 - 18 - 44
Major findings of operations: pelvic abscess; adhesions
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stanley B. Kyanowicz M.D.
Address St. Joseph's Hosp. Date signed 8/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19716 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1506 N. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Hopwood

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Thomas E. Hopwood

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1864

8. AGE: Years	Months	Days	If less than one day
79	11	8	hr. min.

9. Birthplace Harrisonburg, Va. (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name John C. Morrison
13. Birthplace Virginia

MOTHER
14. Maiden Name Henretta H. Stirewalt
15. Birthplace Virginia

16 (a) Informant Mrs T.W.McFadden
(b) Address 2114 Penn Ave. Wilkensburg, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 8. 194 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Frederick & Coy
(b) Address 2008 W. Lombard St.

19 AUG 8 - 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 1944, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944 to Aug 6 1944, and that I last saw her alive on Aug 5 1944

Immediate cause of death hypertensive, arterio-sclerotic cardio-vascular disease — Duration ?

Due to

Due to

Other Conditions Cystitis — 4 wks

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Helen J. Magruder M. D.
Address 1445 N Gay St. Date signed 8/6/44

G19717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G19717 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. Montford Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-2

(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Montford Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Nelson

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 213-01-2216

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lillian Mae Nelson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-6-1895

8. AGE: Years 49 | Months 4 | Days 29 | If less than one day hr. min.

9. Birthplace Richmond Va (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business Balto City

FATHER
12. Name Samuel Nelson
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Lillian Mae Nelson
(b) Address 221 N. Montford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Balto City

18 (a) Funeral director J. P. Gaefkins
(b) Address 1519 Hooker St

19 (a) AUG 8 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5-1944 8:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-18 1944 to 8-5 1944 and that I last saw h[illegible] alive on 8-5 1944.

Immediate cause of death: Lobar Pneumonia and Pleurisy — Duration 3 wks 2 wks

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jas. R. Blake M.D.
Address 1327 N. Central Ave Date signed 8-7-44

G19718

G19718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 Juneway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 Juneway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREIDA THEISS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Geo. M. Theiss

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Oct. 13, 1893

8. AGE: Years 50 | Months 9 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Carl Koch
13. Birthplace Germany

MOTHER
14. Maiden Name Clara Thether
15. Birthplace Germany

16 (a) Informant Geo. M. Theiss
(b) Address 3401 Juneway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Rd.

18 (a) Funeral director Howard N. Bligh
(b) Address 4914 Belair Road

19 (a) Filed [illegible] 1944 [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7th 1944 at 1 45 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ..... death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carcinoma of left breast

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?
(d) Means of injury

23. Signature H. J. Wallenmeier M.D. Medical Examiner.
Date signed 8-7-44

G19719 — BALTIMORE CITY HEALTH DEPARTMENT — G19719

CERTIFICATE OF DEATH

Registered No. 19719

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1025 Light St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Light St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillie C. Windus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: July 3, 1894

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60 | Months 1 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER: 12. Name Werner Windus; 13. Birthplace Baltimore

MOTHER: 14. Maiden Name Sophia Schreyer; 15. Birthplace Baltimore

16 (a) Informant Charles Windus

(b) Address 1025 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9. 1944 (month) (day) (year)

(c) Cemetery or crematory Westview

Location Baltimore Md.

18 (a) Funeral director Flynn & Fleming

(b) Address 1476 Light St.

19 (a) (Date rec'd by registrar) 1944 Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7- 1944, at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1944 to Aug 7 1944 and that I last saw him alive on Aug 6 1944

Immediate cause of death: Acute dilatation of heart — Duration: 24 hr.

Due to: Mitral regurgitation — 2 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. L. Campbell M.D.

Address 1644 Hanover Date signed 8/8/44

G19720

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G19720 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1331 N. Calhoun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas S. Parker

3 (b) If veteran, name war —
3 (c) Social Security Account No. 231-10-5860

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Married.

6 (b) Name of husband or wife Georgiana Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-'96

8. AGE: Years	Months	Days	If less than one day
47	9	29	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER: 12. Name Thomas Parker
13. Birthplace Maryland.

MOTHER: 14. Maiden Name Sarah Wells
15. Birthplace Maryland.

16 (a) Informant Georgiana Parker
(b) Address 1331 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn.
Location Md.

18 (a) Funeral director George F. Kelson
(b) Address 1303 Pennsman St.

19 (a) (Date received by Registrar) AUG 8 1944 Huntington, W. Va. (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-4 1944, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 19 4, to 8-4 19 4, and that I last saw h alive on 19

Immediate cause of death: Cardio Renal Vascular Disease — Duration: 1 Mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Paige
1516 N. Monument St. (17) Date signed 8-8-44 M. D.

H. L. Wallenmeyer M.D. asst. medical Exam.

G19721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G19721

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 223 E 21st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OLE P. HENRIKSEN

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 26, 1888

8. AGE: Years 56 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace Norway (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Norway

MOTHER
14. Maiden Name Unknown
15. Birthplace Norway

16 (a) Informant Norwegian Consul
(b) Address MD TRUST CO BLDG

17 (a) CREMATION (b) Date thereof 8/9/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory GREEN MOUNT
Location BALTIMORE MD

18 (a) Funeral director Wilson Funeral Home
(b) Address 319 E Cold St

19 (a) AUG 8 - 1944 (Date rec'd by registrar) (b) Huntington Wallenmeyer M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1944 at 10 10 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, lobular

Due to Chronic alcoholism

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
for Medical Examiner.
Date signed

G19722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G19722

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #23, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Hollins St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Salvétti

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-9201

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Lena Salvétti
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) April 5, 1891

8. AGE: Years	Months	Days	If less than one day
53	4	1	7 hr. 25 min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Shoemaker
11. Industry or business

FATHER
12. Name Joseph Salvittii
13. Birthplace Italy

MOTHER
14. Maiden Name Anne Ammazzatorgo
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 933 Hollins St. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9. 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Horley St

19 (a) Date received by Registrar (b) Registrar

Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944, at 7:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 2 1944 to Aug. 6 1944, and that I last saw him alive on Aug. 6 1944.

Immediate cause of death	Duration
Cardio - Resp. Failure	12 hrs.
Due to Laryngeal obstruction - possibly Chreinoma with secondary infection.	7 days
Due to Report of biopsy pending	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation August 4, 1944
Major findings of operation: Large mass in larynx & secondary infection
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. E. Hambsch M. D.
Address Mercy Hospital Date signed 8/6/44

ROGERS.

G19723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19723 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8d.
(e) Length of stay in Baltimore (yrs., mos., or days) 16y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County H
(c) City or town Balto H
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 E High St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Will Rogers William L. Rogers.

3 (b) If veteran, name war

3 (c) Social Security Account No. Unknown

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11/1881

8. AGE: Years 63 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Va King George Co., Va.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name William T. Rogers
13. Birthplace King George Co., Va.

MOTHER
14. Maiden Name Rosie B. Rodier
15. Birthplace Washington D.C.

16 (a) Informant Mrs. Philbert L. Rogers
(b) Address 1600 Quincy ST., Arlington Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Potomac Ch. Yd
Location King George Co. Va.

18 (a) Funeral director Thomas W. Simpson (N.F.S.)
(b) Address Glen Burnie, Md.

19 (a) (b)
Filed rec'd by registrar AUG 8 1944
Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/5 1944 at 1:37 PM

21. I certify that death occurred on the date above stated, that I attended deceased from 7/28 1944 to 8/5 1944 and that I last saw h[illegible] alive on 8/5 1944.

Immediate cause of death Card. Resp. Failure — Duration

Due to Cerebral Thrombosis

Due to Hypertensive C-V Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. H. Crosby
Address Mercy Hosp. Date signed 8/8/44

G19724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1117a

G19724

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st St.
(c) Hospital or institution:
US Marine Hospital, Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 Parklawn Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN BERNARD KIEHNE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Evelyn Fitch
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1904

8. AGE: Years	Months	Days	If less than one day
39	8	2	hr. min.

9. Birthplace BALTIMORE, MARYLAND
(Town, county, and state)
10. Usual Occupation Master
11. Industry or business

FATHER
12. Name Herman H. Kiehne
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary ~~Evelyn Fitch~~ Rolfes
15. Birthplace Baltimore, Maryland

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof AUG. 9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE St.

19 (a) (Date received by Registrar) AUG 8 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1944, at 12:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1, 1944, to Aug. 5, 1944, and that I last saw him alive on Aug. 5, 1944.

Immediate cause of death	Duration
Perforated gastric ulcer with marked diffuse peritonitis	4 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. H. Williams M. D.
Address US Marine Hospital, Baltimore, Maryland Date signed 8/5/44

G19725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G19725

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 S.Grundy St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 602 S.Grundy St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Loss

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Henry Loss
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.19,1868

8. AGE: Years	Months	Days	If less than one day
76	5	18	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Frederick Ebert
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Hulsman
15. Birthplace Germany

16 (a) Informant Mrs.Bertha Rommel
(b) Address 602 S.Grundy St.

17 (a) Burial (b) Date thereof 8/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) AUG 9 1944 Huntington Williams Mortuary
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 11 1940, to August 6 1944, and that I last saw h[illegible] alive on August 5 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	1 day
Due to Hypertension	5 yrs.
Due to Arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Michael J. Branch M. D.
Address 2530 E. Baltimore St. Date signed 8/7/44

G19726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

G19726
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1028 Cathedral St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 Cathedral St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHARINE G. SHAW.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Robert L. Shaw.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan 28-1877
8. AGE: Years 67 Months 6 Days 6
If less than one day hr. min.
9. Birthplace Camden N.J.
(Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank L. Vinton
13. Birthplace Unknown

MOTHER
14. Maiden Name Elizabeth Getz
15. Birthplace Md

16 (a) Informant Mrs William Smith
(b) Address 1132 Roland Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-44 (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster Md
18 (a) Funeral director Randell E Humphreys
(b) Address 1501 N. Broadway
19 (a) (Date received) AUG 8 1944 (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3- 1944, at 6 30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1944 to 8-3 1944 and that I last saw h[illegible] alive on 8-3 1944
Immediate cause of death: Cerebral Embolism — Duration 4 Days
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address 1028 Cathedral St Signed [illegible] M. D.

G19727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1228

Registered No. G19727

MARON RESERVED FOR LEADING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1811 Dixon Rd. (If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Mr. Sidney Coombe Vincent

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, (married), widowed, or divorced.
M.	W	

6 (b) Name of husband or wife Mrs. Sidney Vincent (Gwendolyn Vincent) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1883

8. AGE: Years	Months	Days	If less than one day: hr.	min.
60	—	11		

9. Birthplace Maryland (Balto.) (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Iowa Corp.

FATHER
12. Name James C. Vincent (D)
13. Birthplace England

MOTHER
14. Maiden Name Charlotte Blanchard
15. Birthplace New York

16 (a) Informant Wife Mrs. Mary G. Vincent (Wife)
(b) Address Same 1811 Dixon Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-10-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Howard Mamms
(b) Address 1080 W. Mtd. Ave.

19 (Filed by registrar) AUG 8 - 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1944, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944, to Aug 7 1944, and that I last saw him alive on Aug 7 1944.

Immediate cause of death Cardio-Resp. Failure

Duration

Due to Intestinal Obstruction

Due to Regional Enteritis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.
Address U. of M. H. Date signed 9-7-44

G19728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19728 Registered No.

MAKE NO MARKS OUTSIDE RULED LINES RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Wytheville
(If outside city or town limits, write RURAL and give town)
(d) Street No. Visitation Convent (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sister M. Paulina Doyle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1861

8. AGE: Years	Months	Days	If less than one day
83	3	7	hr. min.

9. Birthplace Brockport, New York (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business

FATHER
12. Name Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN & SON.) 108 N. HOWARD AVENUE

19 (a) AUG 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 7, 1944, at 11:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 6, 1944, to Aug. 7 1944, and that I last saw her alive on Aug. 7 1944.

Immediate cause of death: Myocardial infarct — Duration: 1 day

Due to: Arteriosclerosis — Duration: ?

Due to — Duration:

Other Conditions — Duration:

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Damian P. Magee M. D.
Address 336 Cathedral St. (Address of physician who signed)

G19729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G19729 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345½ W Saratoga
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1345½ W Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James L. Spratley
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-05-1396

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Hattie Spratley
6 (c) If alive, give age 71 years
7. Birth date of deceased (mo., day, yr.) May 11 1902

8. AGE: Years	Months	Days	If less than one day
49	7	26	hr. min.

9. Birthplace South Hill Va (town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Green Spratley
13. Birthplace South Hill Va

MOTHER 14. Maiden Name Mary Anna McKinney
15. Birthplace Va

16 (a) Informant Hattie Spratley
(b) Address 1345½ W Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (Date received by registrar) AUG 8 - 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1944, at 10:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944 to Aug 7 1944.
and that I last saw living on Aug 7 1944.

Immediate cause of death	Duration
Coronary Heart Disease	Entire
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature M. D.
Address Date signed

G19730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1469

G19730 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hilleland + Rayner
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Inverness (If outside city or town limits, write RURAL and give town)
(d) Street No. 537 Bayside Dr. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John A Grill

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva (Evan)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 28-1896

8. AGE: Years 48 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace Balto., Md (Town, county, and state)

10. Usual Occupation U.S. Coast Guard

11. Industry or business

FATHER
12. Name John Grill
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Elizabeth Rozeneck
15. Birthplace Bohemia

16 (a) Informant Mrs. Eva Grill
(b) Address 537 Bayside Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-9-1944 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location O'Donnell St. Rd

18 (a) Funeral director John B. Connelly
(b) Address 401 Eastern Ave.

19 (a) AUG 8 - 1944 (Date rec'd by registrar) Huntingtown, Md.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6 1944, at 10:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944, to Aug 6 1944, and that I last saw h.. alive on Aug 6 1944.

Immediate cause of death Pneumonia

Due to Carcinomatosis Jaundice

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Aug 3, 1944

Major findings of operation: Ca of rectum

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Reed W Bachelder M. D.
Address WBGN Date signed 8-8-44

G19731 BEAUMONT G19731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Bruce
(c) Hospital or institution: Univ. Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 35 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Cedar Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lot # 50
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland William Beaumont

3 (b) If veteran, name war Wld War I | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Sylvia (Shaffer) (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1894

8. AGE: Years 50 | Months 3 | Days 4 | If less than one day hr. min.

9. Birthplace Winthrop, Maine (Town, county, and state)

10. Usual Occupation

11. Industry or business Glenn L. Martin Co.

FATHER 12. Name John Beaumont

13. Birthplace Texas

MOTHER 14. Maiden Name Ellen J. Libby

15. Birthplace Ohio

16 (a) Informant Mrs. Sylvia Beaumont

(b) Address Cedar Beach # 50

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 10 1944 (month) (day) (year)

(c) Cemetery or crematory Woodland

Location Taylor Ave.

18 (a) Funeral director John J. Connelly

(b) Address 418 Eastern Ave.

19 (c) AUG 8 1944 (Date rec'd by registrar) Courtney Van Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/6 1944 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/4 1944 to 8/6 1944 and that I last saw h/m alive on 8/6 1944.

Immediate cause of death Pulmonary edema — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Pulm. embolism?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A Robert Markee M. D.
Address University Hosp. Date signed 8/6/44

G19732 X ✓ G19732

BALTIMORE CITY HEALTH DEPARTMENT 36 Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp 9-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 4 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 153 Y Main St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Kathleen S. Uvanni ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Joseph Uvanni
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-13-07

8. AGE: Years	Months	Days	If less than one day
36 39	11	25	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Henry Wirt Shriver
13. Birthplace Md.

MOTHER
14. Maiden Name Alice Le Fevre
15. Birthplace Pa.

16 (a) Informant Hospital record
(b) Address

17 (a) Burial (b) Date thereof 8-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Silver Run
Location Silver Run Md.

18 (a) Funeral director J. E. Myers Jr.
(b) Address Westminster Md.

AUG 9 - 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7 1944 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1944 to 8-7 1944, and that I last saw her alive on 8-7 1944

Immediate cause of death respiratory failure
Due to poliomyelitis
Due to
Other Conditions pharyngeal paralysis
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp. Date signed 8-9-44

G19733 3-28-45

BALTIMORE CITY HEALTH DEPARTMENT 47d G19733

CERTIFICATE OF DEATH

Registered No. [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2005 Linden Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Huber

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. X

6 (b) Name of husband or wife Ruth Huber
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 7-26-95

8. AGE: Years 49 | Months 0 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace New Rochelle, N.Y. (Town, county, and state)

10. Usual Occupation Soft

11. Industry or business Taxidermist Corp.

FATHER: 12. Name Charles Huber
13. Birthplace (Germany)

MOTHER: 14. Maiden Name Christina [redacted] (Germany)
15. Birthplace (Germany)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 8/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bishop Wood Cemetery
Location New Rochelle N.Y.

18 (a) Funeral director William Cook Inc
(b) Address 1317 St. Paul St.

AUG 9 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-7- 1944, at 6:49 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28- 1944 to 8-7 1944, and that I last saw him alive on 8-7- 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to: Ca of rt. lung	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 7/4/44
Major findings of operation: Inoperable Ca of rt. lung.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert D. Horn, M.D.
Address Johns Hopkins Date signed 8/7/44

(over)

G19734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G19734 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3128 Chesley Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-5
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3128 Chesley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** ANNA STASTNY BEERMANN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Paul W. Beermann
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): 10/20/1885

8. AGE: Years 58 | Months 9 | Days 6 | If less than one day: hr. min.

9. Birthplace: Austria (Town, county, and state)

10. Usual Occupation: At HOME

11. Industry or business

FATHER
12. Name: Josef Stastney
13. Birthplace: Austria

MOTHER
14. Maiden Name: Katherine Adamec
15. Birthplace: Austria

16 (a) Informant: Miss Mildred A. Beekman
(b) Address: 3128 Chesley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-9-44 (month) (day) (year)
(c) Cemetery or crematory: Parkwood Cem
Location: Baltimore

18 (a) Funeral director: Henry Sander & Sons, Inc
(b) Address: North Ave & Broadway

AUG 9 - 1944 (date rec'd by registrar) Huntington Holliques M.D. Registrar

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH Aug. 6 1944; 2.58 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Aug 6 1944.
and that I last saw h[illegible] alive on Aug 6 1944

Immediate cause of death: Adeno Carcinoma of Rt Breast — Duration

Due to: Melanoma of Right Eye

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Walter A Anderson M. D.
Address: 300 E Lanvale St Date signed 9/2/44

G19735 ✓ Dr A Adams 71 Bergen St

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G19735

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 N. Eden St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 N Eden St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Erma Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Welford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/4/1902

8. AGE: Years 42 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name James Alston
13. Birthplace N C

MOTHER 14. Maiden Name Josephine Millis
15. Birthplace N C

16 (a) Informant Welford Robinson
(b) Address 1228 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 9 44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location A & C Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 AUG 9 - 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 14 1944 to Aug 6 1944 and that I last saw h[illegible] alive on Aug 5 1944

Immediate cause of death Cerebral Hemorrhage — Duration 4 Days

Due to Hypertensive Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1222 N. Caroline Date signed 8-8-44

VS 180

G19736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19736 Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct ... is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 N. Chester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Chester St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Taylor

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Henry May Taylor
6 (c) If alive, give age
7. Birth date of deceased (mo., day, yr.) July 29 1866
8. AGE: Years 78 Months Days 16 If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Rothamel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Zimmerman
15. Birthplace Germany

16 (a) Informant Mary Weaver
(b) Address 614 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9 44 (month) (day) (year)
(c) Cemetery or crematory Bald Mem
Location Bald Md
18 (a) Funeral director Philip Herring & Son
(b) Address 2024 Eutaw St
AUG 9 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6 1944 at 12:43 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1944 to Aug 6 1944 and that I last saw h[illegible] alive on Aug. 5 1944.

Immediate cause of death	Duration
Diabetic Coma	24 hrs
Due to Diabetes Mellitus	3 years
Due to	
Other Conditions Coronary Sclerosis Arteriosclerosis Hypertension (Include pregnancy within 3 months of death)	?

Date of operation —
Major findings of operations —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Vincent H. Loska M.D.
Address 845 N. Eutaw St Date signed 8/6/44

G19737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. G19737

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Univ of Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days): 27
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md (b) County:
(c) City or town: Balto (If outside city or town limits, write RURAL and give town)
(d) Street No.: 508 Cording Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country:

3 (a) FULL NAME Nellie Frank. (FRANK)

3 (b) If veteran, name war: —
3 (c) Social Security Account No.: —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife: Wm John Frank
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 17 1886

8. AGE: Years	Months	Days	If less than one day
58	3 4	20	hr. min.

9. Birthplace: Balto Md (Town, county, and state)
10. Usual Occupation:
11. Industry or business.

FATHER
12. Name: Richard Proctor
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Martha Houston
15. Birthplace: Baltimore

16 (a) Informant: Wm John Frank
(b) Address: 508 Cording Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 10/44 (month) (day) (year)
(c) Cemetery or crematory: Cyd Grove
Location: Balto Md

18 (a) Funeral director: Phillips Fleming Sons
(b) Address: 2024 Eutaw St

AUG 9 - 1944 Date received by registrar — Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-7 1944 at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1944 to 8-7 1944, and that I last saw h.er alive on 8-7 1944.

Immediate cause of death	Duration
Coronary heart failure	
Due to Chronic Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: J. J. Ranga M. D.
Address: Redwood & Green Sts Date signed 8-7-44

G19738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G19738 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 Barclay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Barclay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Grant

3 (b) If veteran, name war

3 (c) Social Security Account No. H

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1874

8. AGE: Years	Months	Days	If less than one day
69	9	26	min.

9. Birthplace Balto. Md. (town, county and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Isaac Grant
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Hannah ??
15. Birthplace Maryland

16 (a) Informant Margaret Grant
(b) Address 1523 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Wm. E. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received by registrar) (b) Baltimore, Md.
Aug 9 1944

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-5-44 19 , at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 19 44 to 8-5-44 19 , and that I last saw him alive on Aug 5, 19 44

Immediate cause of death: Hypostatic Congestion Cardiac Renal Failure — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marion Calvin M. D.

Address 312 E 23rd Date signed 8-6-44

G19739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G19739

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hosp. 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Tucker.
(c) City or town Albert 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Alexander Ray Knaggs -

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25 - 1942

8. AGE: Years	Months	Days	If less than one day
1	109	9	hr. min.

9. Birthplace Albert, West Va.
(Town, county, and state)
10. Usual Occupation Baby.
11. Industry or business

FATHER
12. Name Vincent Knaggs.
13. Birthplace Junior, West Va.

MOTHER
14. Maiden Name Jeanette Wardlow
15. Birthplace West Va.

16 (a) Informant Father Vincent Knaggs
(b) Address Albert, West Va.

17 (a) Burial (b) Date thereof Aug 7 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Babb Hill
Location Thomas W.Va.

18 (a) Funeral director J. A. Demeree
(b) Address Thomas, W.Va.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 4 1944, at 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944 to Aug 4 1944, and that I last saw h[im] alive on Aug 4 1944.

Immediate cause of death	Duration
Pneumonia	
Bronchial Oedema	
Due to Swallowed a peanut and developed obstruction	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation Tracheotomy 8-3-44
Major findings of operation —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence August 1st at 6 p. M
(c) Where did injury occur? Albert, West Va.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? —
(Specify type of place)
(e) Means of injury swallowed a peanut
23. Signature N Dukeman
Address University Hosp. Date signed M. 8 D. 7/44

19740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19740 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5924 Kavon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5924 Kavon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Weber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John A. Weber
13. Birthplace Baltimore

MOTHER
14. Maiden Name Clara Wagner
15. Birthplace Baltimore

16 (a) Informant Mrs Katherine Weber
(b) Address 5924 Kavon Ave

17 (a) Burial (b) Date thereof 8-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Leonard J. Fuchs
(b) Address 5305 Harford Ave
(c) 8-1944 Huntington Indiana, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1944, at 6:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Roland Lee Graham M.D.
Medical Examiner.
Date signed August 9, 1944

G19741 G19741

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓ 1955

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Orchard Beach (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Kinsey

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-8693

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APRIL 11-1890

8. AGE: Years 54 | Months 3 | Days 27 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation OPERATOR

11. Industry or business PISTON RING Co

FATHER
12. Name ALBERT S. KINSEY
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name MAUD O STALLINGS
15. Birthplace BALTIMORE MD

16 (a) Informant MAUD O KINSEY
(b) Address 1001 W CROSS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-9-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location BALTO MD

18 (a) Funeral director BERNARD C HARLOW
(b) Address 124 E WEST ST

19 (a) AUG 9 - 1944 (Date rec'd by registrar) (b) Huntington Williamsport M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1944 at 2:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Foreign body in glottis; edema of glottis, aspiration of vomitus ?

Due to acute ? alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 7 1944 at 2:30 A.M.
(b) Where did injury occur? Orchard Beach A.A. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
Means of injury Choked on foreign body

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed August 8, 1944

G19742

G19742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 W. 25th. St.
(c) Hospital or institution:
HOME 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) XXXX
(e) Length of stay in Baltimore (yrs., mos., or days) 52 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) ~~XXXXX~~ Baltimore City
(c) City or town Baltimore City 26
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 West 25th. Street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country NO

3 (a) FULL NAME THEODORA HUMPHREYS ELLINGER

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Clarence M. Ellinger
6 (c) If alive, give age XXX years

7. Birth date of deceased (mo., day, yr.): Feb. 21, 1870

8. AGE: Years 74 | Months 5 | Days 17 | If less than one day: ....hr. ....min.

9. Birthplace: Salisbury, Maryland (Town, county, and state)
10. Usual Occupation: NONE
11. Industry or business: NONE

FATHER
12. Name: Daniel Burton Cannon
13. Birthplace: Delaware

MOTHER
14. Maiden Name: Sarah Ann Parker
15. Birthplace: Somerset Co., Md.

16 (a) Informant: Mrs. Howard Runion, Jr. (daughter)
(b) Address: 741 Berkley Ave., Plainfield, N.J.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof: Aug. 10, 1944 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Green Mount Ave. at Oliver, City.

18 (a) Funeral director: Stewart & Mowen Company
(b) Address: 108 W. North Av. (W.F. Wooden-Suc.)

19 (a) AUG 9 1944 (b) Thurlington Williams, M.D. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8, 1944, at 6.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July. 20 1944 to Aug 8, 1944 and that I last saw h er alive on Aug. 7, 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 5 days
Due to: Arterio Sclerosis — 2.
Due to: Hypertension
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at .... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: George H. Cannon M. D.
Address: 28 W 25th St. Date signed: 8-9-44

G19743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1866

G19743 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1130 N. Monroe (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carter Clarke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary Clarke

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1880

8. AGE: Years 64 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Matthews Co. Va. (town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Sarah Clark
15. Birthplace Va

16 (a) Informant Mary J. Clark.
(b) Address 1134 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Lee W. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b)

AUG 9 - 1944

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944 at 1:22 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 | 1 1944 to 8 | 6 1944 and that I last saw h.im alive on 8 | 6 1944

Immediate cause of death Cerebral Concussion — Duration

Due to Fall

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8 | 1 | 44 at 11:30 A.M
(c) Where did injury occur? Baltimore (City or town) State (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public place (Specify type of place) While at work? No
(e) Means of injury Head Struck against something in home

23. Signature C. L. Barnfield

Address Provident Hospital Date signed 8 | 9 | 44 M. D.

Tr 2 Wallenmaker md Cert had. Examined

G19744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19744 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
City or town Huntington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 219 Washington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jackie Scarberry.

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	NONE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 3 1939

8. AGE: Years	Months	Days	If less than one day
5	1	6	hr. min.

9. Birthplace W. Va. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name JACKIE SCARBERRY
13. Birthplace WEST VA.

MOTHER
14. Maiden Name Madaline ?
15. Birthplace KENTUCKY

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 13/44 (month) (day) (year)
(c) Cemetery or crematory UNION RIDGE
Location HUNINGTON WEST VA.

18 (a) Funeral director Lilly and Zeiler, INC.
(b) Address 403 8. ADOLPH AV.

AUG 9 1944 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug- 9- 1944, at 5:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug- 8 1944, to Aug- 9 1944, and that I last saw him alive on Aug- 9 1944.

Immediate cause of death Respiratory Failure
Due to Brain Tumor
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ellis Feer
Address Johns Hopkins Hosp Date signed 8-9-44

G19745

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 1310a

Reg. Dist. No. .....

G19745

1. PLACE OF DEATH:

County Baltimore

City or town Dorchester Heights Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3210 Poplar Ave.

Hospital, institution, or street address where death occurred: 25-2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Baltimore

City or town Dorchester Heights (If outside city or town limits, write RURAL and give nearest town)

Street No. 3210 Poplar Ave (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Joseph Battaglia

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Late Maria Grazia Battaglia

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19 1862 1882

8. AGE: Years	Months	Days	If less than one day
62	3	26	..... hrs. ..... min.

9. Birthplace Cefalu Italy (Town, county, and state)

10. Usual occupation none

11. Industry or business .....

FATHER

12. Name Salvatore Battaglia

13. Birthplace Italy

MOTHER

14. Maiden name Rosaria ?

15. Birthplace Italy

16. Informant Hilda Glorioso

Address 2521 Washington Blvd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 18 1944 (month) (day) (year)

Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd.

18. Funeral director Frank Della Rocca

Address 52 N. Morley St. Baltimore Md.

19. (Date received by local registrar) Aug 8 1944 (Signature of local registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-15-44, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-1-44 to 7-15-44

and that I last saw him alive on 7-15-44

Immediate cause of death Hypostatic Pneumonitis. — DURATION 15 days

Due to Chronic Nephritis & Hypertension — years

Due to old age

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE S. Osnard M. D. or other

Address Medical attendant Date signed 7-16-44

G19746

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH ✓ 937

G19746

Reg. Dist. No. 30

1. PLACE OF DEATH:
Baltimore
City or town Ten Hills (If outside city or town limits, write RURAL and give nearest town)
5313 Edmondson Ave.
How long in above place of death? 28 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. City Baltimore
City or town Ten Hills (If outside city or town limits, write RURAL and give nearest town)
Street No. 5313 Edmondson Ave. (If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Emma Gifford
3.(b) Social Security Number none

4. Sex Female | 5. Color or race White | 6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Hugh Gifford Jr
6.(c) If single, give age ____ years
7. Birth date of deceased (mo., day, yr.) Feb 3. 1860

8. AGE: Years 84 | Months 5 | Days 16 | If less than one day ____ hrs. ____ min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation none
11. Industry or business

MOTHER / FATHER
12. Name James H Parker
13. Birthplace Unknown
14. Maiden name Mary J Unknown
15. Birthplace Md

16. Informant Hugh Gifford Jr
Address 5462 East Ave Rodgers Forge Md
17. Final disposition Burial (Burial, cremation, or removal, which?) Date thereof 7/22/44 (month) (day) (year)
Cemetery or crematory Baltimore
Location Baltimore Md
18. Funeral director Sullivan Bros Inc
Address 1217 E Pratt St
19. AUG 07 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1944, at 9.15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1944 to July 19 1944
and that I last saw her alive on July 17 1944
Immediate cause of death Myocardial Failure — DURATION 3 months
Due to Chronic myocarditis — ?
Due to ____
Other conditions Old Ventral Hernia — years
(Include pregnancy within 3 months of death)
Major findings of operations none Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE Frank N. Ordeni M. D. or other
Address 2701 N. Calvert St. Date signed July 19 44

G19747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1488

G19747 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5315 Gwynn Oak Ave.
(c) Hospital or institution:
28
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5315 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delma K. Grant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Michael J. Grant
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) August 23, 1890

8. AGE: Years	Months	Days	If less than one day
53	11	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A. Jones
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Emma D. Jones
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth C. Elliott
(b) Address 5315 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof Aug. 9,1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. W. Lamoreau
(b) Address 4510 Liberty Heights Ave.

19 AUG 9 - 1944 (b) Huntington Williams, M.D.
(Rec'd by Registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1944, at 2.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/12 1943 to 8/6/ 1944, and that I last saw her alive on 8/5/ 1944

Immediate cause of death	Duration
Coronary thrombosis - -	9 mos
Due to Hypertensive cardio vascular disease.	
Due to	
Other Conditions Malignancy of uterus and adnexa. (Include pregnancy within 3 months of death)	?

Date of operation Not Done
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M. D.
Address 1224 Hanover St. Date signed 8/8/ 1944

G19748 BALLOU ✓ G19748

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2506 Allendale Rd.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME William Mellin Ballou (WILLIAM MELLIN BALLOU)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maude S. Ballou

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Feb 23 1868

8. AGE: Years 76 | Months 5 | Days 11 | If less than one day 9 hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Ballou
13. Birthplace Penna

MOTHER
14. Maiden Name Miss Mellin
15. Birthplace Penna

16 (a) Informant Mrs Maude S. Ballou (wife)
(b) Address 2506 Allendale Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Steward & Mowbray Co.
(b) Address 10 S Howard St

AUG 10 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25 1944 to 8-9 1944 and that I last saw him alive on 8-9 1944

Immediate cause of death C-R-Failure — Duration

Due to Bilateral Bronchopneumonia

Due to CA of Sigmoid Colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J Vernick M.D.

Address Union Memorial Hosp Date signed 8-7-44

G19749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G19749 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County St. Mary's
(c) City or town Ridge (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Harris

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 2, 1944

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Leroy Harris
13. Birthplace South Carolina

MOTHER
14. Maiden Name Bernice Mary Huey
15. Birthplace South Carolina

16 (a) Informant Hospital records
(b) Address John s Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL AUG 9 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH August 3 1944, at 10.05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1944, to Aug. 3 1944, and that I last saw h. im alive on Aug. 3 1944.

Immediate cause of death Prematurity — Duration

Due to Maternal: Toxemia of pregnancy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stepteau, Jr. M. D.
Address Johns Hopkins Hospital Date signed 8-5-44

VS 150

2074

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19750

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 107

G19750
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2229 Penna ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sheila Jeter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-29-41

8. AGE: Years 2 | Months 6 | Days 9 | If less than one day hr. min.

9. Birthplace md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Anglin Talbert
13. Birthplace S. C.

MOTHER
14. Maiden Name Alma Wallace
15. Birthplace md

16 (a) Informant Alma Jeter
(b) Address 2229 Penna ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-44 (month) (day) (year)

(c) Cemetery or crematory mt Auburn
Location md

18 (a) Funeral director George H. Nelson
(b) Address 1303 Pierstmont St. Huntington Station, Md.

19 (a) AUG 10 1944 (Registrar's signature) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1944, at 4 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 7, 1944, to August 8, 1944, and that I last saw her alive on August 5, 1944.

Immediate cause of death Bronchopneumonia — 3. Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Congestion of lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. L. Banfield

Address Provident Hospital Date signed 8/9/44

G19751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G19751
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Hampnett
(c) Hospital or institution: Pine Ridge
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Hampnett (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATHERINE ELLEN LEACH

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1866

8. AGE: Years 78 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace St. Mary's Co., Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John H. Leach
13. Birthplace St. Mary's Co., Md.

MOTHER
14. Maiden Name Lucy Penn
15. Birthplace Charles Co., Md.

16 (a) Informant Mrs. W. P. Graves
(b) Address Chestertown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received) AUG 10 1944 (b) Registrar Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1944 at 8.30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1943 to Aug 7 1944 and that I last saw h[illegible] alive on Aug. 7 1944

Immediate cause of death: Chronic myocarditis — Duration: 10 years
Due to: Coronary sclerosis
Due to: Hypertension
Due to: Arteriosclerosis
Other Conditions: Terminal uremia, Parkinsonism
(Include pregnancy, accident, operation or homicide, if death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. V. Harbold M.D.
Address 4706 Harford Road Date signed 8/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct... is especially important. Physicians: please write the causes of death clearly and legibly.

G19752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

139a

Registered No. G19752

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton and Wilkins Ave
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 Mosher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Shenton (Margaret Augusta Shenton)

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 10, 1906

8. AGE: Years	Months	Days	If less than one day
38 3/7	4	28	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Stenographer
11. Industry or business B. & O. R. R.

FATHER
12. Name Herbert Elmer Shenton
13. Birthplace Md.

MOTHER
14. Maiden Name Jessie E. Scull
15. Birthplace Pittsburgh, Pa.

16 (a) Informant Mrs. Jessie E. Shenton
(b) Address 2306 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Md.
18 (a) Funeral Director WM. J. TICHNER & SONS
(b) Address Baltimore, Md.
19 (a) (Date rec'd by registrar) (b) Registrar

AUG 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1944, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1944, to 8/8 1944, and that I last saw her alive on 8/8 1944.

Immediate cause of death	Duration
Peritonitis	
Diphtheremia	
Due to Tubo-ovarian abcess	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation Tubo ovarian abcess
of autopsy: Peritonitis,

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify trade or place)
(e) Means of injury
23. Signature J. L. Rafferty M.D.
Address St. Agnes Date signed 8/8/44

G19753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19753

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 md
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Reservir ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary H. Silkman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife: Edward J. Silkman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-1864

8. AGE: Years 79 | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace Carthage OHIO
(Town, county, and state)

10. Usual Occupation None Housewife

11. Industry or business

FATHER
12. Name Theophilus French
13. Birthplace ENGLAND

MOTHER
14. Maiden Name MARY DEAN
15. Birthplace ENGLAND

16 (a) Informant Mrs. Catherine L. Chandlee
(b) Address Charleston, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Fichner & Sons
(b) Address Baltimore (Not Wilkens, Md.)

19 (a) (Date received by Registrar) AUG 10 1944 (b) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1944 at 3 29/A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-8 1944 to 8-9 1944, and that I last saw her alive on 8-9 1944.

Immediate cause of death	Duration
CARDIO-RESP FAILURE	
Due to ARTERIO-SCLEROTIC HEART DISEASE	
Due to	
Other Conditions Leg amputation due to Arterial embolus	

(Include pregnancy within 3 months of death)

Date of operation 7-4-44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William H. Lippitt M. D.
Address Union Memorial Hosp Date signed 8/9/44

G19754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G19754 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 233 S. Bouldin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Stewart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs. Mary Stewart

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1880

8. AGE: Years 64 | Months 3 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Theodore Stewart
13. Birthplace Unknown

MOTHER 14. Maiden Name Mary Heath
15. Birthplace Unknown

16 (a) Informant Mary E. Stewart
(b) Address 233 S/ Bouldin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) ... (b) ...
(Date received by registrar) Registrar

AUG 10 1944

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1944 at 6 15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1944 to 8/9 1944, and that I last saw him alive on 8/9 1944.

Immediate cause of death: Card. failure — Duration

Due to Congestive Heart failure

Due to Pneumonia

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. M. N. Crosby

Address Mercy Hosp. Date signed 8/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Keesee ✓ G19755

G19755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1533 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1533 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Keesee

3 (b) If veteran, name war W.
3 (c) Social Security Account No. none

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Dora

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14, 1867

8. AGE: Years	Months	Days	If less than one day
76	7	25	hr. min.

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Robert A Keesee
13. Birthplace Ga

MOTHER 14. Maiden Name Sarah C Chisman
15. Birthplace Ga

16 (a) Informant Lucy C Keesee
(b) Address 1533 Linden Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/11/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn Cem
Location White Post Va

18 (a) Funeral director Wilson Lockhart
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar AUG 10 1944 Huntington for Williams, M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1944, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1- 1944 to 8-9 1944, and that I last saw h[illegible] alive on 8-9- 1944

Immediate cause of death Apoplexie Cerebrale

Duration
?

Due to

Due to

Other Conditions Arteriosclerosis

Duration
1 Years

(Include pregnancy within 3 months of death)

Date of operation 7-30-44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 901 Eutaw Pl Date signed 8/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19756
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs. 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 807 E. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William Stieler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23, 1911

8. AGE: Years 33 | Months 3 | Days 15 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business Salesman & Collector

FATHER
12. Name Henly Stieler
13. Birthplace Germany

MOTHER
14. Maiden Name Selma Wolfe
15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave, Extended

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10 AUG 10 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1944, at 7:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1944, to Aug. 8, 1944, and that I last saw h. im alive on Aug. 8, 1944.

Immediate cause of death: Rheumatic Heart Disease with decompensation and auricular fibrillation

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Pleijoff

Address Balt. City Hosp. Date signed 8-8-44 M. D.

G19757 Bickel ✓ G19757

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94N

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bickel Joseph Bickel Bickel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Cornelia Bickel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 7 1888

8. AGE: Years 56 | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Shoe Store

11. Industry or business

FATHER
12. Name Simon Bickel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Arnold
15. Birthplace Germany

16 (a) Informant Andrew Bickel
(b) Address 1917 E. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 9 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Wm. J. Funeral Home
(b) Address 2008 Orleans St

19 AUG 10 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1944, at 1125 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Traitzer M.D.
Medical Examiner.
Date signed Aug. 9, 1944

G19758

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19758 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Bryant Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 BRYANT AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORA COWEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Arthur M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years: 62 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Isaac Matofsky

FATHER 13. Birthplace Russia

MOTHER 14. Maiden Name Fannie

MOTHER 15. Birthplace Russia

16 (a) Informant Husband

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-10-44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mem Rd

Location Woodlawn Mem Rd

18 (a) Funeral director Jack Levine Inc

(b) Address 1439 E. Balto St

19 (a) AUG 10 1944 (Date rec'd by registrar) Huntington Williams, Inc. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9-44 19 , at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29 1944 to 8/9 1944, and that I last saw h[illegible] alive on 8/4 1944.

Immediate cause of death Death Coronary Occlusion

Duration

Due to

Due to

Other Conditions Hypertension Cardiac enlargement

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Gro.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chester B Levine M.D.

Address 7904 Reisterstown Rd Date signed 8/9/44

G19759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137W

Registered No. G19759

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Arcaza - Corner of Madison St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Taylor Meyers (Taylor Myers)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Anna Zang

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 10, 1866

8. AGE: Years	Months	Days	If less than one day
77	9	29	-- hr. --- min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Meyers
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Zoller
15. Birthplace Virginia

16 (a) Informant John L. Meyers - Son
(b) Address Alcazar, Charles & Madison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meades and Son
(b) Address 505 N. Calvert St.

19 (a) (b) Huntington Hill, Md.

AUG 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1944 at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8-9 1944 and that I last saw h alive on 8-9 1944.

Immediate cause of death	Duration
Respiration Ceased	
Due to Hypostatic Pneumonia	
Due to	
Other Conditions Prostate Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Amchan M. D.

Address Monument Hosp. Date signed 8-9-44

G19760

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G19760 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Windsor Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver K. Neavitt

3 (b) If veteran, name war ---

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Emma S. Neavitt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1869

8. AGE: Years	Months	Days	If less than one day
74	11	14	hr. min.

9. Birthplace Neavitt, Md.
(Town, county, and state)
10. Usual Occupation Retired Mail Carrier
11. Industry or business U.S. Government

FATHER
12. Name Henry Clay Neavitt
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ann Neavitt
15. Birthplace Md.

16 (a) Informant Neavitt
(b) Address 3115 Windsor Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

19 (a) [illegible] (b) Huntington Williams, M.D.

AUG 10 1944
VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9, 1944, at 3.00 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from apr. 6/44 19 to aug 9 1944, and that I last saw him alive on aug 8 1944.

Immediate cause of death	Duration about 1 yr.
Cardio vascular disease	
Due to advanced arterio sclerosis ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S. Tuffett M. D.
Address 2220 Garrison Blvd Date signed aug 9/44

G19761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932 G19761 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 643 Haw Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 643 Haw Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1885

8. AGE: Years 59 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name James Smith
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Ellen Gaines
15. Birthplace Alexander Va.

16 (a) Informant Edith Smith
(b) Address 643 Haw Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location

18 (a) Funeral director Walter S. Hines
(b) Address 139 N. Howard St

19 (a) AUG 10 1944 (Date rec'd by Registrar) (b) Huntington Pollard, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1944, at 4 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)
Date signed August 8, 1944.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

619762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 195 W ✓ G19762 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Maryland
(b) Street address
(c) Hospital or institution South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Greenland Beach, Curtis Bay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Lee Gayman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 25, 1944

8. AGE: Years	Months	Days	If less than one day
	1	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William Gayman
13. Birthplace U. S. A.

MOTHER
14. Maiden Name Helen Buchman
15. Birthplace Carnea Pa.

16 (a) Informant William Gayman
(b) Address Curtis Bay P.O. Greenland Beach

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/10/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Ritchie Highway A.A. Co.

18 (a) Funeral director Earl L. Hess
(b) Address 715 Light St.

19 AUG 10 1944 (Date received by local registrar) Farrington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1944, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, Lobular
Due to Aspiration of vomitus

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber, M.D.
Medical Examiner.
Date signed August 10, 1944.

G19763

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G19763 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 179 W main ST.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Nellie W. Pearre

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Carroll Co, Maryland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

FATHER
12. Name Charles V Wantz
13. Birthplace Carroll County md

MOTHER
14. Maiden Name Caroline Virginia Pearre
15. Birthplace md

16 (a) Informant Mr James P Wantz
(b) Address 179 W main St, Westminster

17 (a) Buried (b) Date thereof Aug 12 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster Cemetery
Location Westminster, Maryland

18 (a) Funeral director E. Myers Jr.
(b) Address Westminster, Maryland

AUG 10 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 10 1944, and that I last saw h. alive on Aug 10 1944

Immediate cause of death Cardio vascular accident

Due to Hypertension

Due to metastasis from Cancer of Breast

Other Conditions Diagnosed at operation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address Univ. Hosp. Balto., Md. Date signed 9/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Reg. no. G19764 11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5103 Greenhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County V
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5103 Greenhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Berdie M. Hook.

3 (b) If veteran, name war

3 (c) Social Security Account No. –

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife –

6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1893

8. AGE: Years	Months	Days	If less than one day
about 50	7	11	..... hr. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Edward L. Hook
13. Birthplace Maryland.

MOTHER
14. Maiden Name Lucinda J. Armacost.
15. Birthplace Maryland.

16 (a) Informant Bernadine Schiere
(b) Address 5103 Greenhill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12/44 (month) (day) (year)

(c) Cemetery or crematory Maryland Park
Location Taylor Ave.

18 (a) Funeral director C. Brunell & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) ..... (b) ..... (Date received by Registrar) (Registrar)

AUG 10 1944

Huntington Station, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1944, at 8a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1944 to Aug 9 1944 and that I last saw h[illegible] alive on Aug 9 1944.

Immediate cause of death	Duration
Myocardial Insufficiency	1 day
Due to Cardio-renal-Vascular Disease	2 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Wilson M. D.
Address 617 W. 40th Date signed 8/10/44

G19765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G19765 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Ziegler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Miriam E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-29-1888

8. AGE: Years	Months	Days	If less than one day
56	5	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Davidson Chemical

FATHER
12. Name George Ziegler
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Winchester
15. Birthplace Md

16 (a) Informant Clarence Ziegler
(b) Address 3519 Hickory Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md

18 (a) Funeral director Shermanth + Donnan
(b) Address 361 E. Chase St

19 (a) AUG 10 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1944, at 3:15 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed August 9, 1944

VS 151

23 Bagwell
1644 S Hanover St

G19766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G19766

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 20 Poultney St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Poultney St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Ruehl

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: Estelle Ruehl

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23 - 1876

8. AGE: Years 67 | Months 68. | Days 9 | 23 | If less than one day hr. min.

9. Birthplace Baltimore (town, county, and state)

10. Usual Occupation Retired Janitor

11. Industry or business

FATHER
12. Name Henry Ruehl.
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Bernhardt
15. Birthplace Germany

16 (a) Informant Mrs. Maggie Dages
(b) Address 20 Poultney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12-1944 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore

18 (a) Funeral director Maguire Cook & Dyer
(b) Address 1600 W. North Ave

19 (a) (Date rec'd by registrar) AUG 10 1944 Registrar

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1944 at 1-50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944 to Aug 10 1944 and that I last saw him alive on Aug 10 1944

Immediate cause of death: Exhaustion — Duration 7 dys.

Due to: Cerebral Hemorrhage — Duration 2 wks.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 1644 Hanover St Date signed Aug 12 1944

1767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G19767 108 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 17
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1055 Argyle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ivy Bishop
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-05-9790

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	MARRIED

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 22, 1912

8. AGE: Years	Months	Days	If less than one day
32	4	17	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation LABORER
11. Industry or business

FATHER
12. Name William Bishop
13. Birthplace Md.

MOTHER
14. Maiden Name Olive Wilson
15. Birthplace Md.

16 (a) Informant Virginia Bishop
(b) Address 1055 Argyle Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8/13/44 (month) (day) (year)
(c) Cemetery or crematory Taylor's Island
Location Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) AUG 10 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1944, at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9, 1944 to Aug. 9, 1944, and that I last saw h[illegible] alive on Aug. 9, 1944.

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Massive consolidation both lower lobes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Banfield, M.D.
Address Provident Hospital Date signed 8/10/44

G19768

JL - 84350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G19768 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-25

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 509 W. Biddle St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Spear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1869

8. AGE: Years	Months	Days	If less than one day
55	0	16	hr. min.

9. Birthplace N. Y. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER

12. Name Arnold Waters

13. Birthplace Md.

MOTHER

14. Maiden Name Lizzie Jones

15. Birthplace N. Y.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Geo. Halstead

(b) Address 918 Druid Hill Ave

19 (a) AUG 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 9, 1944 19 , at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1943, to 8-9 1944, and that I last saw her alive on 8-9 19 44.

Immediate cause of death	Duration
Carcinoma ductus rectus - rectal fistula -	
Due to Psoas abscess & extension to vertebra.	Unknown
Due to	
Other Conditions Carcinoma of breast.	Unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Recto rectal fistula + psoas abscess

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

Signature Houck E. Bolton M.D.

Address Balt. City Hosp Date signed 8/10/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G19769

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 Chapel gate Ka.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) — 28 4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 224 Mallow Hill Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Bennett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: A. Virginia Bennett
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 6-1874

8. AGE: Years 70 | Months 3 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Thurmont Md
(Town, county, and state)

10. Usual Occupation Manager.

11. Industry or business Restaurant

FATHER
12. Name Henry Bennett
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline Rhodes
15. Birthplace Md

16 (a) Informant Mrs. A. Virginia Bennett
(b) Address 224 Mallow Hill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 11-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park.
Location Balto Md

18 (a) Funeral director Guy L. Berger Jr
(b) Address 1512 Hollins St

AUG 1 1944 Huntington Williams, M.D. Registrar
(a) Date received (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1944, at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-7 1941 to 8-8 1944, and that I last saw h[illegible] alive on 8-8 1944

Immediate cause of death: Carcinoma of Rectum — Duration 1 yr.

Due to:

Due to:

Other Conditions: Hemiplegia due to Cerebral hemorrhage — Duration 3 yr.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hilary F. Gallagher M. D.
Address Catonsville, Md. Date signed 8-8-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the to the cause of death clearly and legibly.

G19770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered G19770

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 W Lanvale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Carrie H. Kreissig

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles A Kreissig
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 1878

8. AGE: Years 66 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Meeth
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Schleiber
15. Birthplace: Germany

16 (a) Informant: Charles A Kreissig
(b) Address: 2824 W Lanvale St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8 11 44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Baltimore Md

18 (a) Funeral director: Wilhelm Bros Inc
(b) Address: 1217 W Fayette St

19. (a) AUG 11 1944 (Date received by Registrar) (b) Huntington Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1944, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25 1944 to 8-9 1944 and that I last saw her alive on 8-9 1944.

Immediate cause of death: Generalized Carcinomatosis — Duration

Due to: Ca Colon

Due to:

Other Conditions: Hx of Skin Lesion Path-Fx. Surg. Path. at Hosp.
(Include pregnancy within 3 months of death)

Date of operation 4-25-44.

Major findings of operation: Biopsy of left Sup. gland — Tumor

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Fract. Surg. neck
(b) Date of occurrence at M
(c) Where did injury occur? Home — Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home ? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Vogel Jr. M.D.
Address Bon Secour Hosp Date signed

H L Wollenweber M D made examination 8-9-44

G19771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G19771
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 E Oliver St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Balto.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 16
(d) Street No. 1732 E. Oliver St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Ruckle
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: W
6 (a) Single, married, widowed or divorced.
6 (b) Name of husband or wife James S Ruckle
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 9 1870
8. AGE: Years 73 74 | Months 9 | Days 0 | If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER 12. Name John C. Cumming
13. Birthplace Germany

MOTHER 14. Maiden Name Mary McKneight
15. Birthplace Germany.

16 (a) Informant William Ruckle
(b) Address 1732 E. Oliver St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. North Ave

18 (a) Funeral director Wendell E Humphreys
(b) Address 801 N. Broadway

19 (a) (b) Huntington Md. Registrar

Registered AUG 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9-44 19 at 545 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 23 19 44 to Aug 9 1944, and that I last saw her alive on Aug 9 1944

Immediate cause of death: Diabetic Gangrene and Diabetic Coma
Due to: Diabetes Mellitus and General Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration: 2 Days, 8 Yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Albert Rosenberg
Address 2025 E. North Ave Date signed 8/10/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G19772

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2003 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Kaplan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Rosa Kaplan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Mrs. Hyman Schevrew
(b) Address 2003 Linden Ave

17 (a) Burial, cremation, or removal (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Mishkin Israel
Location Smithen Ave.

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Baltimore St. Baltimore, Md.

19 AUG 11 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10-1944, at 1:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4-44 1944 to 8-10 1944, and that I last saw alive on 8-10 1944

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Arteriosclerosis cardiovascular renal	
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Myron J. Myron M. D.
Address Sinai Hospital Date signed 8-10-44

VS 150

G19773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G19773

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1605 N. Payson st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 N. Payson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Blacker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife TONA Blacker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Mrs Robert Kweldsmith
(b) Address 1605 N. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Pikesville Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1431 E. Balto St.

19 (a) AUG 11 19 Huntington Williams, M.D.
(Registered by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9-44 19, at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1940 to Aug 9 1944, and that I last saw h[illegible] alive on Aug 9 1944.

Immediate cause of death Coronary occlusion — Duration 1 day

Due to Arteriosclerosis — 2 — 2 yrs

Due to myocardial insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 19[illegible] M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Levinson M. D.
Address 4884 Liberty Heights Ave Date signed 8/9/44

G19774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G19774 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St

(c) Hospital or institution: Sinai Hospt.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3316 Hunter Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MORRIS SILBERT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Fannie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Woodworker

11. Industry or business

MOTHER | FATHER

12. Name Not Known

13. Birthplace Russia

MOTHER

14. Maiden Name Minnie

15. Birthplace Russia

16 (a) Informant Hospt Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)

(c) Cemetery or crematory Mt Carmel

Location O Donnel St

18 (a) Funeral director Jack Levy Inc

(b) Address 1439 E. Balto St

19 AUG 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 1944, at 5:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1944, to 8-10 1944, and that I last saw him alive on 8-10 1944

Immediate cause of death Respiratory failure

Due to Carcinoma of lungs & metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Ingram D. Ingram M. D.

Address Sinai Hospital Date signed 8-10-44

G19775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G19775 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 W. North Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Askin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years 57 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Ferdinand Mintzer
13. Birthplace Austria

MOTHER
14. Maiden Name Sarah
15. Birthplace Austria

16 (a) Informant Mrs. Manson
(b) Address 731 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto & Gorsuch St

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balt St

19 (a) AUG 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1944, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1944 to 8/10 1944, and that I last saw her alive on 8/10 1944.

Immediate cause of death	Resp. failure	Duration
Due to	Cerebro vascular accident	
Due to	Hypertensive arterio-sclerotic h. dis.	
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Hemorrhage into rt. brain

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Askin M.D.
Address Sinai Hosp. Date signed 8/10/1944

G19776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G19776

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1526 Boyle Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Kann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Mary F. Kann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1876

8. AGE: Years	Months	Days	If less than one day
67	11	20	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Box maker
11. Industry or business

FATHER
12. Name Salmon Kann
13. Birthplace Prussia

MOTHER
14. Maiden name Minna Oestricher
15. Birthplace Germany

16 (a) Informant Mrs. Benj. Kann
(b) Address Fidelity Bldg.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/11/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Harris Sondheim & Son
(b) Address 1902 Eutaw Place

19 (a) AUG 11 1944 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8, 1944, at 11 A. M

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning. Probably accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 2/3
(a) Date ~~of injury~~ found 6:30A. at August 8, 1944 M.
(b) Where did injury occur? west side of Broadway Pier,
(c) Did injury occur at home, on farm, industrial place, in public place? Public, While at work? No.
(d) Means of injury Found Drowned

23. Signature H L Wollenweber M.D.
Medical Examiner.
Date signed August 8, 1944.

G19777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G19777

Registered No.

Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Even correct age is especially important. Physicians: please write

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 679 N. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Slacum (E.R)

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-4594

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Marie Slacum

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6/1895

8. AGE: Years 48 | Months 8 | Days 3 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name Luther Marion Slacum
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Virginia Florence
15. Birthplace Virginia

16 (a) Informant Ina Elizabeth Naill
(b) Address 3322 Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12/1944 (month) (day) (year)
(c) Cemetery or crematory Glenbrook Baptist
Location Weems Va.

18 (a) Funeral director Harry H. Annacott
(b) Address 1320 Ridgewood Ave Huntington Park, Md.

19 (a) AUG 11 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 1944, at 9.30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Laceration of right lung
Due to Fracture of ribs.
Other Conditions Accidental Fall.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-9-44 M
(b) Where did injury occur? 679 N. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Fell in bath tub.

23. Signature H. L. Wollenweber M.D. (Medical Examiner.)
Date signed August 11 1944.

JL - 8[illegible]9778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G19778
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please see that correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 1257
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Fox St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Stewart

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1944

8. AGE: Years	Months	Days	If less than one day
	5	21	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Howard Vincent Stewart
13. Birthplace Salto, Md.

MOTHER
14. Maiden Name Louella Ellicott
15. Birthplace Baltimore, Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary A. G. Co.
Location

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St.

19 (a) (Date received by registrar) AUG 11 1944 (b) Registrar's signature Huntington Williams, M.D.

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-8- 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4- 1944, to 8-8- 1944, and that I last saw her alive on 8-8- 1944.

Immediate cause of death	Duration
Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Bilateral Bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh W. Josephs
Address Balt City Hosp Date signed 8/14/44

9779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 95B

Registered No. G19779

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Raymen Ave & Parkdale Rd

(c) Hospital or institution West Balto. Gen. Hosp. 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Rosedale Parkville (If outside city or town limits, write RURAL and give town)

(d) Street No. 2818 Emerald Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Blakeney (Fannie M. Blakeney)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Raymond H. Blakeney

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 22th 1891

8. AGE: Years	Months	Days	If less than one day
53	1	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Reilly

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary Duff

15. Birthplace Baltimore Md.

16 (a) Informant Raymond H. Blakeney

(b) Address 2818 Emerald Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 12, 1944 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location Taylor Avenue

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

AUG 11 1944

(Date rec'd by registrar) Huntington Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/9 1944 at 11:47 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1944 to 8/9 1944.

and that I last saw h[illegible] alive on 8/9 1944.

Immediate cause of death Multiple Arterial Emboli — Duration 7 day

Due to Pheumatic Heart Dis.

Due to Auricular fibrillation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: R.H.D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Irving J. Taylor M.D.

Address WBGH Date signed 8/9/44

G19780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

Registered No. G19780

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3/4 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena, (If outside city or town limits, write RURAL and give town)
(d) Street No. Stoney Creek Road. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Atkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1928

8. AGE: Years 14 | Months 10 | Days 23 | If less than one day 4 hr. 40 min.

9. Birthplace Pasadena, Anne Arundel, Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business School

FATHER 12. Name Henry W. Atkins
13. Birthplace Virginia

MOTHER 14. Maiden Name Florence Gessmac
15. Birthplace Maryland

16 (a) Informant Henry Atkins
(b) Address Marley Neck Rd. Pasadena

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Earl L. Hess
(b) Address 713 Light St.

19 (a) AUG 11 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1944, at 4 40/ PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1944 to Aug 9, 1944, and that I last saw him alive on Aug. 9 1944

Immediate cause of death: Circulatory Collapse — Duration

Due to Intestinal obstruction

Due to Mesentery Hernia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation August 8, 1944

Major findings of operation: Mesentaic hernia & intest. obstruction.

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Hambrook M. D.

Address Mercy Hospital Date signed 8/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G19781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G19781

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 E. Clement St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 109 E. Clement St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Nellie Glenwood Skinner

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John P. Skinner
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 11, 1863

8. AGE: Years	Months	Days	If less than one day
81	1	28	hr. min.

9. Birthplace Washington D. C. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at Home

FATHER
12. Name Absalom Brown
13. Birthplace Laurel, Md.

MOTHER
14. Maiden Name Ellen Lewell
15. Birthplace Washington, D.C.

16 (a) Informant Mrs. John P. Skinner
(b) Address 109 E. Clement St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Rd.

18 (a) Funeral director James L. McCully
(b) Address 130 E. Fort Ave

19 (a) AUG 11 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1944, at 1220 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-27-1944 to 8-7-1944 and that I last saw h.e.r. alive on 8-7-1944.

Immediate cause of death	Duration
Asphyxia	
Due to Pneumonia (T6)	
Due to Tuberculosis pulmonary.	
Other Conditions Myocardiac degeneration of heart, Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. Weinberger M. D.
Address 102 E. Fort Ave Date signed 8-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied.

G19782 Same

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171 A

G19782 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville
(c) Hospital or institution: St. Agnes Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) Nine
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 19
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5811 Bland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Leishear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Winifred Lemmon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1901

8. AGE: Years	Months	Days	If less than one day
42	8	16	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Painting Contractor
11. Industry or business Own Business

FATHER
12. Name Albert L. Leishear
13. Birthplace Md.

MOTHER
14. Maiden Name Alice R. Colein
15. Birthplace Md

16 (a) Informant Mrs Winifred Leishear
(b) Address 5711 Bland Ave

17 (a) Burial (b) Date thereof 8-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) AUG 11 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 9 1944, at 11 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple Fractures of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 20/6 A
(a) Date of injury August 9, 1944 10:45 A.M.
(b) Where did injury occur? Frederick Ave & Hilton St
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place While at work? No
(d) Means of injury Struck by streetcar

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed August 9, 1944

Bohannan

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G19783

G19783

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Walker Ave
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 Holmehurst
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Bohannan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Herbert B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 1, 1877

8. AGE: Years 67 65 | Months 6 | Days 7 | If less than one day ____ hr. ____ min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Theodore Chaney
13. Birthplace Md

MOTHER
14. Maiden Name Mary Jones
15. Birthplace Md.

16 (a) Informant Mr. Herbert B. Bohannan
(b) Address 16 Holmhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Welsh
(b) Address 4101 Edmondson Ave

Huntington Williams, M.D.
(Local registrar) Registrar

AUG 11 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1944, at 7:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/19 1944 to 8/8 1944
and that I last saw her alive on 8/8 1944

Immediate cause of death: Cardiac Standstill

Due to: Myocardial Degeneration aparanca

Due to: Chronic Pancreatitis Retroperitoneal Abscess.

Other Conditions

(Include pregnancy within 3 months of death)

Duration

Date of operation

Major findings of operation: Acute Pancreatitis Retroperitoneal Abscess

Underline the cause to which death should be charged in case of autopsy: Chronic Pancreatitis Retroperitoneal Abscess

PHYSICIAN

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. L. Kaffenberger M. D.
M. D.

Address St Agnes Hosp. Date signed 8/8/44

G19784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 83a

G19784 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 352 N Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-8
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DEASEASED:
(a) State N. Y. (b) County
(c) City or town Flushing (If outside city or town limits write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Schaffer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife William H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 16, 1873

8. AGE: Years 71 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles E. Burke
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie M. Grimes
15. Birthplace Virginia

16 (a) Informant Mr. Robert Burke
(b) Address 352 N Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day), (year)

(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Witzke
(b) Address 4104 Edmondson Ave

19 (a) AUG 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 8. 8 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5- 1944, to 8-8- 1944 and that I last saw h[illegible] alive on Aug 8 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days
Due to: Arterio Sclerosis — ?
Due to: Interstitial Myocarditis — 7 yrs.
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. E. Nichols M. D.
Address Pikesville Md Date signed 8-9-44

G19785

G19785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G19785

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hosp. 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 120 E Greenmount Ave Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 120 E Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward M Frost

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Marie Dwyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1890

8. AGE: Years	Months	Days	If less than one day
54	6	2	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Plato Frost
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Frances Hines
15. Birthplace Balto Md.

16 (a) Informant Mrs Mary Hammond
(b) Address 1208 Greenmount.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14/44 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edgar W Conklin & Son
Address 924 E. Eager St.

19 (a) AUG 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10, 1944, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/07 19 44 to 8/10 19 44
and that I last saw h[illegible] alive on 8/10 19 44

Immediate cause of death	Duration
Resp. Fail.	
Due to Carcinoma of Lung	8-12 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Jane Dolley M. D.
Address Date signed

G19786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 46B

G19786 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hosp 2706
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13Dys
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto #14 (If outside city or town limits, write RURAL and give town)
(d) Street No. 5507 Elsinore Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Philip Gleisner

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-01-9878

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Helena Gleisner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2 1880

8. AGE: Years	Months	Days	If less than one day
64	4	7	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Sexton
11. Industry or business

FATHER
12. Name Bernard Gleisner
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Wilhelm
15. Birthplace Germany

16 (a) Informant Philip B. Gleisner
(b) Address 7114 Chalon Rd CHAMBERS Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location

18 (a) Funeral director George Schilling & Sons
(b) Address 3624 Gwynnbrook Ave BALT

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 11 1944 Huntington

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1944 at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1944 to 8-9 1944 and that I last saw him alive on 8-9 1944.

Immediate cause of death Cardio-Resp Failure — Duration

Due to Bilateral Bronchopneumonia

Due to Carcinoma of Stomach & intestinal obstruction

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bilateral Bronchopneumonia Carcinoma of Stomach & intestinal obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. Cantillon MD M. D.
Address Union Memorial Hosp Date signed 8-9-44

BALTIMORE CITY HEALTH DEPARTMENT 83a

G19787 CERTIFICATE OF DEATH G19787 Registered No. [redacted]

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1437 Henry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1437 Henry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madora C Raines

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F M	W	Widowed

6 (b) Name of husband or wife Walter A
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1873

8. AGE: Years	Months	Days	If less than one day
70	9	2	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housework at home
11. Industry or business

FATHER
12. Name Edward Harding
13. Birthplace Dorchester Co Md

MOTHER
14. Maiden Name Catherine Ward
15. Birthplace Dorchester Co Md

16 (a) Informant Robert L Raines
(b) Address 1437 Henry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/44 (month) (day) (year)
(c) Cemetery or crematory Int Carmel Cem
Location Donnell st

18 (a) Funeral director William M Marsh
(b) Address 715 Light St

AUG 11 1944 Date received — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 9 1944, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 1944, to Aug 9 1944, and that I last saw he alive on Aug 8 1944.

Immediate cause of death	Duration
Terminal Bronchopneumonia	
Due to Cerebral hemorrhage	
Due to Arterio-sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris A. Fine M. D.
Address 118 S Bond St Date signed 8/11/44

Morris A. Fine

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 181

G19788
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lutherville (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Seminary Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret V. Carver

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Conard D. Carver
6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) May 10, 1916

8. AGE: Years	Months	Days	If less than one day
28	3	1	____hr. ____min.

9. Birthplace Lutherville Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Shocke
13. Birthplace Balto. Co. Md.

MOTHER
14. Maiden Name Helena Brooks
15. Birthplace Balto. Md.

16 (a) Informant Conard D. Carver
(b) Address Lutherville md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk.
Location Taylor Ave., Balto.

18 (a) Funeral director Sandow M. Brooks
(b) Address Sparks, md

19 (a) AUG 11 1944 (Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 9, 1944 M.
(b) Where did injury occur? Lutherville
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Clothes caught fire from gasoline

23. Signature Robert Lee Shocke M.D. Medical Examiner.
Date signed August 11, 1944

G19789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 D

G19789 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. Hosp. 6 N
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 19 N. Kenwood ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Myers (Majerowicz)
3 (b) If veteran, name war
3 (c) Social Security Account No. 261-07-3855

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Tillie Myers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9 1915

8. AGE: Years 25 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Majerowicz
13. Birthplace Poland

MOTHER 14. Maiden Name Lillian Rogawski
15. Birthplace Baltimore Md

16 (a) Informant Mrs Tillie Myers
(b) Address 19 N. Kenwood ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof aug 12/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem
Location Baltimore Co.

18 (a) Funeral director John M. Welker
(b) Address 461 S. Chester Street

19 (a) (Date received by local registrar) (b) Registrar

AUG 1 3 1944
Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/8 1944, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1944 to 8/8 1944, and that I last saw h/m alive on 8/8 1944.

Immediate cause of death Hodgkin's disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Robert Marks M. D.
Address University Hosp. Date signed 8/8/44

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19790

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

Registered No. G19790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St
(c) Hospital or institution West Balto Gen Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. 3024 Calif. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dianne Jager

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 | 31 | 44

8. AGE: Years | Months: 5 | Days: 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Jager
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Doris L. Leight
15. Birthplace Baltimore Co.

16 (a) Informant Charles Jager
(b) Address 3024 Calif. Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Cem.
Location Baltimore Co. Parkville Md.

18 (a) Funeral director L. F. Keigh
(b) Address 5306 Harford Rd

19 (a) AUG 11 1944 (Date received) (b) Huntington Wm Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1944 to 8/9 1944, and that I last saw h.. alive at 1:30 P.M. 8/9 1944

Immediate cause of death Unknown

Duration 24 Hrs.

Due to

Due to

Other Conditions Acute Otitis Media, Diarrhea, Dehydration
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Mesenteric Adenitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J Jagla
Address W2GHI Date signed 8/9/44

G19791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

✓ G19791 Registered No.

MARG... RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1530 Baker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yr 15d
(e) Length of stay in Baltimore (yrs., mos., or days) 43yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1530 Baker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Gross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife William Gross
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1901

8. AGE: Years	Months	Days	If less than one day
43	4	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name George Cheeley
13. Birthplace Md.

MOTHER
14. Maiden Name Janet Mack
15. Birthplace Md.

16 (a) Informant Louise Baptist
(b) Address 1530 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-44 (month) (day) (year)
(c) Cemetery or crematory St Peters cem.
Location md

18 (a) Funeral director George G. Kelson
(b) Address 1303 Presstman St

19 (a) AUG 11 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 19XX, at 145 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 19XX, to Aug 8 19XX, and that I last saw her alive on Aug 6 19XX.

Immediate cause of death	Duration
Carcinoma	6 mo's.
Right Breast	
Due to Metastases	3 mo's
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William Frey M. D.
Address 1928 Park Ave Date signed 8/4/44

G19792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19792 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2206 Eastern Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Eastern Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDERICK DEITRICK FABER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Emily M. Faber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Mar 10, 1857

8. AGE: Years 87 | Months 4 | Days 21 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Watchman -Ret. 17 yrs
11. Industry or business: railroad

FATHER
12. Name: John Faber
13. Birthplace: Germany

MOTHER
14. Maiden Name: Catherine ?
15. Birthplace: Germany

16 (a) Informant: Mrs. Ferdinand Faber
(b) Address: 2206 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel
Location: Balto. Md

18 (a) Funeral director: Henry Sander & Sons, Inc
(b) Address: North Ave. & Broadway

1944 AUG 11 1944 (b) Huntington Hill Registrar
(Date rec'd by Registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 9, 44 19 , at 3.20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1944, to Aug 9 1944, and that I last saw him alive on Aug 5 1944.

Immediate cause of death — Duration
Pulmonary Oedema — 1 day
Due to: Myocardial Segment — yrs
Due to: Senile Pneumonia — 5 days
Due to: Arterio - Sclerosis — yrs
Due to: Emphysema — yrs

*Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature: G. F. Ries M. D.
Address: 24 S. Broadway Date signed: Aug 10/44

COR Prow

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G19793 Registered No. G19793

MAKE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1509 N. Mulberry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1509 N. Mulberry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME James Thomas Corprew

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-20-3120

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Lillian

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 29-1924

8. AGE: Years 19 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Bath N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Westinghouse Elec.

FATHER 12. Name Thomas Corprew

13. Birthplace N. C.

MOTHER 14. Maiden Name Hannah Arthur

15. Birthplace N. C.

16 (a) Informant Lillian Corprew

(b) Address 1509 N. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Balto. Md.

18 (a) Funeral director Williams & Jackson

(b) Address 916 Penna. Ave.

AUG 11 1944 (Date rec'd by Registrar) Huntington for Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-6 19 44 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2 19 44 to 8-6 19 44, and that I last saw him alive on 8-6 19 44; that the immediate cause of death was as follows:

	Duration
Immediate cause of death: Coronary Occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address 2 [illegible] Date signed 8-6

G19794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 128

Registered No. G19794

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 677 George Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lutischie Humphries Nolan

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frances

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30. 1902

8. AGE: Years 41 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Major Strand
13. Birthplace

MOTHER
14. Maiden Name Sarah ?
15. Birthplace N. C.

16 (a) Informant Bertie Copeland
(b) Address 677 George Street

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-11-44 (month) (day) (year)
(c) Cemetery or crematory Philadelphia
Location Shelby N. C.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 AUG 11 1944 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9 19 44, at 3 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Acute pancreatitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed August 10, 1944.

G19795 BALTIMORE CITY HEALTH DEPARTMENT G19795
CERTIFICATE OF DEATH 93 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Ellen Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte A Salanda

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6, 1891

8. AGE: Years	Months	Days	If less than one day
52	10	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles M. Hartman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Kohlmann
15. Birthplace unknown

16 (a) Informant Mr. Karl Salanda
(b) Address 5436 Belair Rd.

17 (a) BURIAL (b) Date thereof 8/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

AUG 11 1944 (b) Huntington Williams, M.D.
(Registrar's signature)
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1944, at 3:45 PM

21. I certify that I took charge of the remains described above, held an Investigation thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Hartman M.D.
Medical Examiner.
Date signed August 10 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19796

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19796 ✓ 8/a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 N. Gilmore St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Roland Hayes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1943

8. AGE: Years | Months: 8 | Days: 5 | If less than one day: hr. min.

9. Birthplace md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Albert Hayes
13. Birthplace md

MOTHER
14. Maiden Name Mary Monk
15. Birthplace md

16 (a) Informant Albert Hayes
(b) Address 1031 N. Gilmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Hugo B. Nelson
(b) Address 1363 Pennsylvania St

19 (a) AUG 11 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1944, at 5 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Meningitis, pneumococcic

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed August 11 1944

JL - 85254 G19797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G19797

13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Division St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Bachelor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife James

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6, 1917

8. AGE: Years	Months	Days	If less than one day
27	4	3	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Cleveland Carroll
13. Birthplace Va.

MOTHER
14. Maiden Name Macy Harrison
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 8-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lacrosse
Location Va.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Aug 11 1944 (b)
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9-44 19 , at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-6-1943 to 8-9 1944, and that I last saw her alive on 8-9 1944

Immediate cause of death Pulmonary tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Perry M. D.
Address City Hospitals Date signed 8-11

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C19798 ✓ C19798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1938 Lemmon Av
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Baby Narda Carruthers

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Mr. Richard Carruthers
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 8. 1944
8. AGE: Years 0 | Months 5 | Days 2 | If less than one day hr. min.
9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Richard. Carruthers
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Jacquelyn. Foxgrove
15. Birthplace Petersburg Va

16 (a) Informant Mrs K. Carruthers
(b) Address 193 E. Lemmon Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/44 (month) (day) (year)
(c) Cemetery or crematory Balto National
Location Frederick Rd

18 (a) Funeral director Thos J Kenny
(b) Address Holbrook Gilmor

19 (a) (Date rec'd by registrar) (b) Registrar

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10/44 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/44 to 8/10/44 and that I last saw h.e.r alive on 8/9/44.

Immediate cause of death Acidosis — Duration 8 days
Due to Infectious Diarrhea
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas. Norton, Jr.
Address Bon Secours Hosp. Date signed 8/10/44

G19799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G19799 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 9th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3959 Park Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lawson Dougherty
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Hannella Dougherty
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1899

8. AGE: Years	Months	Days	If less than one day
45	1	24	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Salesman.
11. Industry or business Consolidated Edison Co.

FATHER
12. Name William Dougherty
13. Birthplace Balto

MOTHER
14. Maiden Name Catherine Lawson
15. Birthplace Balto

16 (a) Informant Hannella Dougherty
(b) Address 825 N Mayumont

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14-44 (month) (day) (year)
(c) Cemetery or crematory Mem. Park
Location Old Frederick Rd.

18 (a) Funeral director John A. McDonnell
(b) Address 4501 Greenmount Ave

19 (a) (Date rec'd by reg.) (b) Huntington Williams M.D. Registrar
AUG 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 19 44 to 8/10 19 44 and that I last saw h alive on 8/10 19 44

Immediate cause of death Cardiac Failure — Duration

Due to Hypertension — 4 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Jane Foley M. D.
Address Mercy Hospital Date signed

G19800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19800 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Robinson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 601 N. Robinson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eliza E. Duval

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Frank. W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 8-1858
8. AGE: Years 86 | Months 4 | Days 3 | If less than one day hr. min.
9. Birthplace: York. Pa. (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business

FATHER: 12. Name: Adolph Weisheit
13. Birthplace: Pa.

MOTHER: 14. Maiden name: Susanna Benetz
15. Birthplace: Pa.

16 (a) Informant: Ida. E. Dubelbeiss
(b) Address: 601 N. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date of burial (mo.) (day) (yr.)
(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore Md.

18 (a) Funeral director: John A. McCann
(b) Address: 300 E. Baltimore St.

19 (a) AUG 11 1944 (Date rec'd by registrar) (b) Thursday (Registrar)

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1944 at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5 1944 to Aug 10, 1944. and that I last saw her alive on Aug 7 1944.

Immediate cause of death: Cardio-Vascular disease
Due to: Hypertension
Due to: Arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

Duration: ? 4 days.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

Signature: Louis J. Kliner M. D.
Address: 2627 E. Monument Date signed: 8/11/44

G19801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G19801 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 Warner St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 Warner St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isaac Gamble

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 219-07-6883

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida Gamble

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 53 | Months | Days | If less than one day hr. min.

9. Birthplace: Maryland. (Town, county and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER 12. Name: John Gamble
13. Birthplace: md

MOTHER 14. Maiden Name: Mariah Gamble
15. Birthplace: md

16 (a) Informant: Ida Gamble
(b) Address: 1116 Warner st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/12/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Memorial
Location:

18 (a) Funeral director: Chas O. Wilson
(b) Address: Washington Boulevard & Monroe St. Baltimore Md

AUG 12 1944 (Date rec'd by registrar) Registrar

VS 150

Aug 9, 1944 **MEDICAL CERTIFICATION** 9:45 PM

20. DATE OF DEATH: Aug 9 1944, at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1944 to Aug 9 1944, and that I last saw him alive on Aug 9 1944

Immediate cause of death: Acute Suppression of Urine ?

Due to: Probably Acute nephritis ?

Duration: 3 days

Due to:

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Johnnie Gaines

Address: 665 W. Barre Date signed: 8/11/44

Spec. 6-9-19—H. P. Co.—1000 Blks.

G19802

HEALTH DEPARTMENT—CITY OF BALTIMORE

G19802

CERTIFICATE OF DEATH.

REGISTERED NO. 30

1-PLACE OF DEATH City Hood Nursing Home 131a

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5313 Edmondson Ave ST.; WARD)

2-FULL NAME Mary E. Adams 28-4

(a) RESIDENCE. NO. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. A. Adams

6 DATE OF BIRTH (month, day, and year) July 20 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co
(State or country)

PARENTS

10 NAME OF FATHER Henry N. Cassell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Babylon

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Wood
(Address) 5313 Edmondson Ave

15 AUG 12 1944

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1944

17 I HEREBY CERTIFY, That I attended deceased from July 26th, 1944, to July 27, 1944, that I last saw her alive on July 29, 1944, and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Chronic Nephritis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Hypertension

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Frank M. Oden M. D.

, 19 (Address) 2701 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cassell Cemetery Carroll Co	July 31 1944

20 UNDERTAKER ADDRESS

H. D. Benhard & Sons Hydes Md.

MAILED [illegible], 19..... [illegible]

...E should be stated EXACTLY. PHYSICIANS should state...
...mation should be carefully supplied. AGE should be stated...
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA...
TION is very important. See instructions on back of certificates.

G19803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19803 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3705 Edmondson Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3705 Edmondson Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John B Garvey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Caroline M

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1892

8. AGE: Years 51 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Phila Pa (Town, county, and state)

10. Usual Occupation Mgr, Balto Office
11. Industry or business Dairy Balto Co

FATHER 12. Name John Garvey
13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine Hardy
15. Birthplace Ireland

16 (a) Informant John B Garvey
(b) Address 3705 Edmondson Road

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8-12-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Philadelphia Pa

18 (a) Funeral director Runge & Farley
(b) Address Fulton & Fayette

19 (a) (Signature and title) (b) AUG 12 1944 Huntington Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10 1944 at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 30 19XX to Aug 10 19XX, and that I last saw him alive on Aug 9 1944.

Immediate cause of death: Right Coronary artery occlusion — Duration: Since July 30 19XX
Due to: Myocardial infarct — Duration: July 30 19XX
Due to: Kidney failure Heart — Duration:
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William R Keagle M.D.
Address 10 E Eddy St Date signed 8/12/44

VS 180

G19804 ✓ X ✓ G19804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Cutler Aves.
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 1 A Cypress Drive - 20 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Baby Girl Hawthroop

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1944

8. AGE: Years	Months	Days	If less than one day
			10 hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation newborn
11. Industry or business

FATHER
12. Name Alfred J. Hawthroop
13. Birthplace

MOTHER
14. Maiden Name Cora M. Eggbardt
15. Birthplace Baltimore

16 (a) Informant Cora Hawthroop
(b) Address 1A Cypress Drive - 20

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 11 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 12 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1944 to 8/5 1944 and that I last saw h[illegible] alive on 8/5 1944

Immediate cause of death (1) Congenital Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jane M. Wilder M.D.
Address Ensor Mansion Date signed 8/7/44

2076

G19805 ✓ BALTIMORE CITY HEALTH DEPARTMENT X ✓ G19805

CERTIFICATE OF DEATH 159

Registered No.

MARGINS RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmount
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1223 Dunglen Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia Yeonne Walree

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/5/44

8. AGE: Years	Months	Days	If less than one day
—	—	3	— hr. — min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Alfred Ramon Walree
13. Birthplace Roanoke, Virginia

MOTHER
14. Maiden Name Yeanne Louise Pielque
15. Birthplace Boonsboro, N.H.

16 (a) Informant Yeanne Louise Walree
(b) Address 1223 Dunglen Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 11 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 12 1944 Huntington Williams M.D.
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 8 1944, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 4 1944, to August 9 1944, and that I last saw her alive on August 7 1944.

Immediate cause of death Prematurity (Seven weeks prior to term) — Duration

Due to —

Due to —

Other Conditions Hydramnios

(Include pregnancy within 3 months of death)

Date of operation No operation

Major findings of operation: —

of autopsy: partial atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm L. Miller M. D.
Address 6 East Eager St Date signed Aug 8/44

2075

G19806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

96

G19806 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 N. Front St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. Front St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Angelo Del Negro

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 213-10-9950

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	Married

6 (b) Name of husband or wife Adelina Del Negro
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24 1881

8. AGE: Years	Months	Days	If less than one day
62	7	17	hr. min.

9. Birthplace Santa Rona Italy (Town, county, and state)
10. Usual Occupation Coat presser
11. Industry or business Tailor Shop

FATHER
12. Name Corino Del Negro
13. Birthplace Italy

MOTHER
14. Maiden Name Maria D. Carminini
15. Birthplace Italy

16 (a) Informant Elizabeth Rossi (Daughter)
(b) Address 217 N. Front St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 14/44 (month) (day) (year)
(c) Cemetery Holy Redeemer
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Joseph Della Rose
(b) Address 52 N. Morley St.

19 (a) AUG 12 1944 (Registrar's signature) Baltimore, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1944, at 10-30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 11, 1943, to Aug. 11, 1944, and that I last saw him alive on Aug. 10, 1944.

Immediate cause of death	Duration
Aneurysm of thoracic aorta	1 year
Due to Arteriosclerosis	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene L. Cesaroni M. D.
Address 5 E. of Druid Park Date signed Aug. 11, 1944

G19807

TH. 76506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

82

G19807
Registered No.

PLACE OF DEATH:
Baltimore City, Maryland
(a) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr 11 month 27 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 526 S. Bethel St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Niziolk
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Victoria
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 15, 1891
8. AGE: Years 52 Months 7 Days 26 If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business
FATHER 12. Name Michael Niziolk
15. Birthplace Poland
MOTHER 14. Maiden Name Frances ?
15. Birthplace Poland
16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Baltimore
18 (a) Funeral director Fred. W Ozarowski
(b) Address 1344 Eastern Ave
19 AUG 12 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION
20. DATE OF DEATH Aug 11th 1944 19 , at 12.50 M
21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1942 to 8/11 1944 and that I last saw h[illegible] alive on 8/11 19 44
Immediate cause of death Bronchopneumonia Lobular
Due to Sclerosis
Due to
Other Conditions Emaciation, Arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Shea Halle
Address BCH Date signed 8/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G19808

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Flint St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Poca St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-0737

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1880

8. AGE: Years	Months	Days	If less than one day
63	9	28	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Edward Johnson
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Julia Waters
15. Birthplace Howard Co. Md.

16 (a) Informant Nellie Daly Robinson
(b) Address 1433 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Date received) AUG 12 1944 (b) Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1944 at 12:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy & autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Loss death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic
Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grafton M.D.
Medical Examiner.
Date signed August 7 1944

40-466 G19809 BALTIMORE CITY HEALTH DEPARTMENT G19809
CERTIFICATE OF DEATH
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland-
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Ja Paid Jane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Percy R Barry
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna
6 (c) If alive, give age 57 years
7. Birth date of deceased (mo., day, yr.) 11/9/87

8. AGE: Years	Months	Days	If less than one day
56	9	2	hr. min.

9. Birthplace N J (Town, county, and state)
10. Usual Occupation Reliable Hearing Co
11. Industry or business

FATHER
12. Name Lewis Barry
13. Birthplace New York

MOTHER
14. Maiden Name Charlotte Jengstreet
15. Birthplace New York

16 (a) Informant Relatives
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) CREMATION (b) Date thereof AUG. 11-1944 (month) (day) (year)
(If burial, cremation, removal)
(c) Cemetery or crematory GREENMOUNT
Location

18 (a) Funeral director Chas J. Evans Son
(b) Address 118 W. Mt Royal Ave

19 (a) (b) Registrar
Filed AUG 12 1944 Registrar
Vs 116 Remington for Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1944 at 7 56 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 22 1944, to Aug 10 1944, and that I last saw him alive on Aug 10 1944.

Immediate cause of death Uraemia — Duration

Due to Carcinoma prostate

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Prosti M. D.
Address Johns Hopkins Hosp Date signed

G19810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19810 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Milton B. Merkle

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret E. Merkle,
6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) October 7, 1899

8. AGE: Years	Months	Days	If less than one day
44	10	4	....hr. ....min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Policeman,
11. Industry or business City

FATHER
12. Name John B. Merkle,
13. Birthplace Va.

MOTHER
14. Maiden Name Alice M. Horton,
15. Birthplace Va.

16 (a) Informant Mrs Margaret E. Merkle,
(b) Address 1307 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Robert S. Little,
(b) Address 2700 Edmondson Ave.

19 AUG 12 1944 (b) Huntington Millspaugh, M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1944, at 12 45 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Aug. 11, 1944

G19811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G19811 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 N. Lexington St.
(c) Hospital or institution: Volunteers of America
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Middle River Rte. 14 Box 72
(If outside city or town limits, write RURAL and give town)
(d) Street No. Bird River Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Philip James Neil
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~.
M	W	

6 (b) Name of ~~husband~~ or wife Helen A. Neil
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Nov 18, 1897

8. AGE: Years	Months	Days	If less than one day
56	9	23	hr. min.

9. Birthplace Liverpool, England (Town, county and state)
10. Usual Occupation Financial Secretary
11. Industry or business Plumbers Union

FATHER
12. Name Joseph Neil
13. Birthplace England

MOTHER
14. Maiden Name ?
15. Birthplace England

16 (a) Informant Wife
(b) Address Middle River, Rt. 14 Box 72

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 AUG 12 1944 (Date received by Registrar) (b) Huntingdon Pharmacy, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1944 at 9.30 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944 to Aug 11 1944, and that I last saw ~~him~~ alive on Aug 10 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Cerebral Arteriosclerosis	
Hypertrophied Arteriosclerosis	
Due to Arteriosclerosis CVHD	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leland Applefeld M. D.
Address 251 Reisterstown Rd Date signed

G19812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

G19812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 South Wolfe Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 426 South Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Drega

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~Mary~~ Simon deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1864

8. AGE: Years 80 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Miss. Florence Drega (Daughter)
(b) Address 426 South Wolfe Street

17 (a) Burial (b) Date thereof 8-14-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) Date Received AUG 12 1944 (b) Harting for Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11th 1944, at 12 02 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1940 to Aug. 11 1944 and that I last saw h. alive on Aug. 11 '44

	Duration
Immediate cause of death: Myocardial Insufficiency	10 days
Due to: Hemiplegia	10 days
Due to: Hypertension	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Zagrobicki M. D.
Address 1802 Eastern Date signed 8-11-44

G19813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 D

G19813
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp. 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 750 Vine St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 9 Months Days If less than one day hr. min. y.v.

9. Birthplace Macklinburg Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lee Smith
13. Birthplace Prince Betty, Va

MOTHER
14. Maiden Name Nicie Braddock
15. Birthplace Prince City Va

16 (a) Informant Lee Smith
(b) Address 750 Vine St

17 (a) Burial (b) Date thereof Aug 13, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Keysville, Va.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 AUG 12 1944 (b) Huntington Williams, Undr.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Concussion of brain

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 18/2

(a) Date of injury August 10 1944 M.
(b) Where did injury occur? Garage 3 Lexington St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No Employ
Means of injury Struck by truck while riding

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Aug 11, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered G19814

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5330 Dennmore ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 18
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5330 Dennmore Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Brayton Lowe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	colored	widowed

6 (b) Name of husband or wife Archer Lowe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1892

8. AGE: Years	Months	Days	If less than one day
52	1	13	hr. min.

9. Birthplace Buckingham Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name Arthur Wyatt
13. Birthplace Va

MOTHER
14. Maiden Name Bettie Johnson
15. Birthplace Va

16 (a) Informant Charles Brayton
(b) Address 5330 Dennmore ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) Aug 12 1944 (b) Huntington Williams, Reg.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 – 9 – 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7 – 30 – 1944, to 8 – 9 – 1944, and that I last saw her alive on 8 – 9 – 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	11 days
Due to Hypertension & arteriosclerosis	unknown
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 10 29 N. Stricker Date signed 8-11-44

M. D. B. 1262-6

G19815 ✓ G19815

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 132

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 548 W. Lee St., Ward)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Joseph Worsey

(a) Residence: No. 548 W. Lee St., 22-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	Col.	married

5a. If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Redia West-Worsey

6. DATE OF BIRTH (month, day, year) May 15, 1893

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	2	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Baltimore, Md
(State or country)

FATHER

13. NAME William Worsey

14. BIRTHPLACE (city or town) Montgomery Co. Md.
(State or country)

MOTHER

15. MAIDEN NAME Mary Green

16. BIRTHPLACE (city or town) Baltimore, Md
(State or country)

17. INFORMANT Redia W. Worsey

(Address) 548 W. Lee St.

18. BURIAL, CREMATION, OR REMOVAL

Place Burial Mt. Auburn Cemetery Date Aug 14, 1944

19. UNDERTAKER Mrs Kate R. Wilgus

(Address) 322 N. Edmondson Ave.

20. AUG 12 1944, 19... Huntington for Williams, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug. 9, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 26, 1944, to Aug. 9, 1944

I last saw him alive on Aug. 8, 1944. Death is said to have occurred on the date stated above, at 2 40 A.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary T.B.	3 wks
Other contributory causes of importance: Bronchitis	May 1944

Name of operation..... Date of.....

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? Possibly If so, specify Sulphuric Acid Plant

(Signed) McDonald Bando M. D.

(Address) 2445 D. Hill Ave.

V. S. 2

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G19816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

Registered No. G19816

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Highland Drive
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Highland Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DOROTHY O. McGUIRE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife: Matthew A Maguire

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-1891

8. AGE: Years	Months	Days	If less than one day
52	9	13	hr. min.

9. Birthplace Balto. Md.
(Town, county and state)

10. Usual Occupation Saleslady (Schleisner)

11. Industry or business Grocery

FATHER 12. Name Frederick Drake

13. Birthplace

MOTHER 14. Maiden Name Lida Finlayson

15. Birthplace

16 (a) Informant Jane Chap Butterfield

(b) Address 717 Highland Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore

18 (a) Funeral director Leonard Hyatt

(b) Address 5305 Harford Rd

AUG 12 1944 (c) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1944 at 12 45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to Suicide

Other Conditions Mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-44 at M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury kitchen stove

23. Signature H. L. Wollammeier M.D.
Medical Examiner.
Date signed 8-14-44

G19817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G19817

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3823 Hamilton Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3823 Hamilton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia P. Beacham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Frank A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1875

8. AGE: Years	Months	Days	If less than one day
68	9	3	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Frederick Vinup
13. Birthplace Prussia

MOTHER
14. Maiden Name Lena Sapp
15. Birthplace Germany

16 (a) Informant Mr. Frank A. Beacham Jr.
(b) Address 3823 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 12 44 (month) (day) (year)
(c) Cemetery or crematory Pk. Knoll
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 AUG 12 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/10 1944, at 8:9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/ 1944, to 8/10 1944, and that I last saw h alive on 8/10 1944

Immediate cause of death Adeno Carcinoma of Cervix — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hyland G. Jeffery M. D.
Address 5203 Harford Rd Date signed 8/11/44

G19818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19818 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3314 HUDSON ST.
(c) Hospital or institution:
26-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 HUDSON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MAMIE KROPFELDER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: GEORGE N. KROPFELDER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): JULY 27 1893

8. AGE: Years 51 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: FRANK RUPP
13. Birthplace: BALTO. MD.

MOTHER
14. Maiden Name: MOLLIE CALLIE
15. Birthplace: BALTO. MD.

16 (a) Informant: GEORGE N. KROPFELDER (HUS.)
(b) Address: 3314 HUDSON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 14/44 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BELAIR ROAD

18 (a) Funeral director: Lilly & Zeiler Inc.
(b) Address: 403 S. WOLFE ST.

AUG 12 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH AUG. 10 1944 at 11/45

21. I certify that death occurred on the date above stated; that I attended deceased from July 2 1943 to Aug. 10 1944 and that I last saw h[illegible] alive on Aug 8, 1944

Immediate cause of death: Embolism Failure
My preturm Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 2529 Eastern Ave. Date signed 8/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The color, age is especially important. Physicians: please write the causes of death clearly and legibly.

G13819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 442

Registered No. G19819

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2923 Christopher Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles L. Hess

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Married

6 (b) Name of husband or wife Elda L. Hess
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13-1912

8. AGE: Years	Months	Days	If less than one day
32	2	19	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Clerk Circuit Court
11. Industry or business

FATHER
12. Name Charles Hess
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Elda L. Hess
(b) Address 2923 Christopher Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-15-44 (month) (day) (year)
(c) Cemetery or crematory Woodland Perm
Location Balto Co. Parkville Md.

18 (a) Funeral director H. G. Peck
(b) Address 5305 Harford Rd.
(c) Name of registrar Huntington Williams M.D.

AUG 13 1944

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1944 at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1944 to 8-12 1944 and that I last saw h. alive on 8-12 1944.

Immediate cause of death Myocardial Failure — Duration
Due to Anemia
Due to Hodgkins disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Range M. D.
Address Univ. Hosp. Date signed 8-12-44

JL - 8865 G19820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓

G19820 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Lyndhurst St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dora Hunt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Div.

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 13, 1883

8. AGE: Years	Months	Days	If less than one day
60	7	26	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name William Geiger
13. Birthplace Germany

MOTHER
14. Maiden Name Dora Taylor
15. Birthplace Germany

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-12-44 (month) (day) (year)
(c) Cemetery or crematory Oakelawn
Location Balto. Co. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 247 Lt. and St. Huntington Williams, Md.

19 (a) AUG 13 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 9, 1944, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-2 19 44 to 8/9 19 44
and that I last saw h[illegible] alive on 8/9 19 44

Immediate cause of death: Bronchio-pneumonia — Duration 2 days
Due to
Due to
Other Conditions Hypertension. Cardio vascular Renal Disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Shea Halle
Address BCH Date signed 8/11/44

G19821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19821 663

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Univ. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 dys
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Charles
(c) City or town Hughesville (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Goldsmith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, divorced. Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years 42 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Abe Goldsmith
13. Birthplace Md

MOTHER 14. Maiden Name Ida Goldsmith
15. Birthplace Md

16 (a) Informant University Hospital Records
(b) Address Redwood & Greene St.

17 (a) Removal (b) Date thereof 8-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hughesville
Location Hughesville, Charles County

18 (a) Funeral director Elmer M. Quade
(b) Address Hughesville, Charles County

AUG 13 1944 (b) Huntingtown Md
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11-44 19 , at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-23 1944 to 8-11-44, and that I last saw h.. alive on 19

Immediate cause of death: Cardiac Failure — Duration

Due to Hemochromatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas O'Neil M. D.
Address Elmer Hospital Date signed 8-12-44

G19822

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

46F

G19822
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: Fourth Balto. Gen. 24
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 da
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 181 Meadow Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Price.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Lena

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Aug 23, 1893

8. AGE: Years	Months	Days	If less than one day
50 ?			hr. min.

9. Birthplace Warrington W Va.
(Town, county, and state)

10. Usual Occupation Coast Guard

11. Industry or business

FATHER
12. Name S. J. Price
13. Birthplace Warrington W Va.

MOTHER
14. Maiden Name Virginia ?
15. Birthplace

16 (a) Informant Mrs Lena Price
(b) Address Loveland, Colorado.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1944 (month) (day) (year)

(c) Cemetery or crematory Loveland Cem.
Location Loveland, Colorado

18 (a) Funeral director Earl L. Hess
(b) Address 715 Light St

AUG 13 1944 (a) Registrar (b) Huntington, W. Va.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1944 at 12 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1944 to 8-11 1944 and that I last saw h[illegible] alive on 8-11 1944.

Immediate cause of death — Duration

Primary Carcinoma
Due to of the Liver.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1211 Light St Date signed 8-11-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19823 G19823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/9/44 7:35 PM
(e) Length of stay in Baltimore (yrs., mos., or days) Since 8/9/44 7:35 PM

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town 809 24th St., Columbus
(If outside city or town limits, write RURAL and give town)
(d) Street No. 809 24th St., Colbumbus
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PHENIX, Horace Edmerson (Ser.#690-83-66 USNR)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct. 25, 1926
8. AGE: Years 17 | Months 9 | Days 17 | If less than one day hr. min.
9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Sea-2/c (3rd Naval Dist.
11. Industry or business U.S.Navy (Booklyn Navy Yd.)

FATHER
12. Name Alex Phenix
13. Birthplace ? Ga.

MOTHER
14. Maiden Name Eva Poor
15. Birthplace Ga.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-44 (month) (day) (year)
(c) Cemetery or crematory Riverside Cemetery
Location Midland Ga.

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Rd.

AUG 12 1944 (Date rec'd by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1944, at 12:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9, 1944 to Aug. 11, 1944, and that I last saw him alive on Aug. 11, 1944.

Immediate cause of death: Laceration of spinal Cord, Cervical — Duration: 18 hrs.
Due to: Dislocation 6th Cervical vertebra — 18 hrs.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident Balto. Co. P.
(b) Date of occurrence August 9, at 44 6:00 M
(c) Where did injury occur? Bay Shore, Balto., Md. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Beach While at work? (Specify yes or no)
(e) Means of injury: Sliding down chute into water, struck water & twisted back.

23. Signature Louis E. Lurie M. D.
Address U. S. Marine Hosp. Date signed 8/11/44 M. D.

USN-54732

G19824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

G19824

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3612 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EARL MORRIS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY-20-1922

8. AGE: Years 22 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation BRAKEMAN

11. Industry or business P. RR

FATHER
12. Name UNA H. MORRIS
13. Birthplace VA.

MOTHER
14. Maiden Name Lucy O'Quinn
15. Birthplace Georgia

16 (a) Informant Una H. Morris
(b) Address VA.

17 (a) Removal (b) Date thereof 8/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Grove Hill Cem
Location Shenandoah VA.

18 (a) Funeral director Wm Cox Inc.
(b) Address 1217 E. Paul St.

19 AUG 13 1944 (b) Huntington W. Va.
(Date received by local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944 at 6 34 M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of extremities

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-12-44 at 6 a 26/4 M.
(b) Where did injury occur? Bay View Yd. Penn. RR
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? Yes
(d) Means of injury crushed between cars

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 8-14-44

G19825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G19825 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 Warrenton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 Warrenton Road (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Ella M. Flannery

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frank J. Flannery
6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1862

8. AGE: Years	Months	Days	If less than one day
81	7	15	-- hr. -- min.

9. Birthplace Weston, West Virginia (Town, county, and state)
10. Usual Occupation -------
11. Industry or business -------

FATHER
12. Name Henry Brannon
13. Birthplace Virginia

MOTHER
14. Maiden Name Jane Arnold
15. Birthplace Weston, West Virginia

16 (a) Informant Charles C. Conlon, Jr.
(b) Address 40 Warrenton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meades and Son
(b) Address 805 N. Calvert Street

AUG 13 1944 (b) Director of Vital Statistics Baltimore, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944, to Aug 12 1944, and that I last saw h[illegible] alive on Aug 10 1944.

Immediate cause of death	Duration
Hypertension Cardiovascular Disease	Unknown
Due to Arteriosclerosis	Unknown
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. B. Goodbrand M. D.
Address 7923 St Paul St Date signed 8/12/44

G19826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G19826

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3634 E. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3634 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Paetow

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Emil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 — 1863

8. AGE: Years 81 | Months 1 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Conrad Dickert
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Kintzer
15. Birthplace "

16 (a) Informant Mrs. B. Lynn
(b) Address Fort Howard, P.O. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave Road

18 (a) Funeral director John G Rosan
(b) Address 3000 E Baltimore St

19 (a) (b)
(Date received) (year)

AUG 13 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1944 at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1944, to Aug. 11, 1944, and that I last saw her alive on Aug. 9, 1944.

Immediate cause of death Myocarditis (chronic) — Duration 6 mos

Due to Arteriosclerosis — Duration 2

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cronin M. D.
Address 514 Drury Lane Date signed 8/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T. C. P. 57451

G19827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19827
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 years 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2635 Kirk Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank C. Pearson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1864

8. AGE: Years	Months	Days	If less than one day
79	11	10	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Building Inspector
11. Industry or business

FATHER
12. Name Franklin Pearson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Susana Cook
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Cemetery
Location Harford Co. Md.
18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place
19 (a) Filed AUG 13 1944 (Registrar) (b) Registered by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10, 1944 19..., at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 1944 to 8/10 1944 and that I last saw him alive on 8/10 1944

Immediate cause of death Arteriosclerotic Heart disease — Duration

Due to

Due to

Other Conditions Parkinsonism
Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Silas Halle

Address BCH Date signed 8/11/44

G19828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3a

G19828 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 Linden Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Linden Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel M. Eanes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Luda Woodall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1886

8. AGE: Years 58 | Months 3 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Henry Co., Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Clay Eanes
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Charles S. Craig
(b) Address 1325 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/44 (month) (day) (year)
(c) Cemetery Mt. Valley
Location Henry County, Va.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

AUG 13 1944
(Date rec'd by registrar) Huntington Mitchell

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to 8/12 1944, and that I last saw him alive on 8/12/1944

Immediate cause of death: Cerebral Hemorrhage — Duration 4 days

Due to: Arterio-sclerosis Hypertension — Duration Several

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W H Woody M.D.
Address 1403 Park Ave. Date signed 8/13/44

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AUG 13 1944

G19829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19829
Registered No.

MARK "X" IN BLACK INK. RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 Pitcher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 26 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 627 Pitcher St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Grant

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 12. 1886

8. AGE: Years	Months	Days	If less than one day
57	11	21	hr. min.

9. Birthplace Northumberland Co. Va.
(Town, county, and state)
10. Usual Occupation Laundress
11. Industry or business Md. Gen. Hospital

FATHER
12. Name William Allen
13. Birthplace Va.

MOTHER
14. Maiden Name Unknown
15. Birthplace Va.

16 (a) Informant George Lee
(b) Address 627 Pitcher St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md.
18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave
19 (a) [illegible] registrar Huntington Williams M.D.

AUG 13 1944

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3/44 19 to 8/10/44 19, and that I last saw h[illegible] alive on 8/9/44 19

Immediate cause of death: Tuberculosis Duration

Due to Poor Circulation

Due to Malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Cn Stein M. D.
Address 507 Mt. Royal Ave Date signed 8/10/44

G19830

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G19830 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Finksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ivan J Keck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Winfred D. Keck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1906

8. AGE: Years 38 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Carroll Co.
(Town, county, and state)

10. Usual Occupation Bethlehem Fairfield.

11. Industry or business

FATHER
12. Name John W. Keck
13. Birthplace Carroll Co

MOTHER
14. Maiden Name Agnes Brown
15. Birthplace Carroll Co.

16 (a) Informant Mrs J Engler
(b) Address Westminster Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15-44 (month) (day) (year)
(c) Cemetery or crematory Sandymount
Location Carroll Co

18 (a) Funeral director P. Bankard & Son
(b) Address Westminster Md.

19 (a) AUG 13 1944 (Registrar) (b) Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944, at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hus death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 12 1944 4 P M.
(b) Where did injury occur? 1/2 mile N. of Reisterstown
(c) Did injury occur at home, on farm, industrial place, in public place? West minster Pike While at work? No
(d) Means of injury Fell from motor cycle

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Aug. 13 1944

G19831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

G19831 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 657 W. Lexington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 657 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Duncan MacDonald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Ida Elizabeth MacDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1867

8. AGE: Years	Months	Days	If less than one day
77	3	17	hr. min.

9. Birthplace Canada
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Augus MacDonald
13. Birthplace Scotland

MOTHER
14. Maiden Name Margaret Gillis
15. Birthplace Scotland

16 (a) Informant Mr. Duncan MacDonald
(b) Address 657 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Catonsville, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 1005 W. Baltimore St.

19 (a) (b) Huntington Williams, M.D.
(Signature of Registrar)

AUG 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Aug 8 1944, and that I last saw him alive on Aug 8 1944.

Immediate cause of death
(a) Carcinoma of Bladder
Due to
(b)
Due to
(c)
Other Conditions

Duration
3 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm F Corson M. D.
Address 4012 Edmondson Ave. Date signed 8/12/44

G19832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19832
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5106 Wesley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5106 Wesley Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel McNeil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Mary Lillie McNeil
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1873

8. AGE: Years	Months	Days	If less than one day
71	4	16	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired Tax Agent
11. Industry or business Baltimore & Ohio RR Co

FATHER
12. Name Hugh McNeil
13. Birthplace Scotland

MOTHER
14. Maiden Name Alice Reinhart
15. Birthplace Ireland

16 (a) Informant Mr. Lawrence McNeil
(b) Address 3706 Ferndale Ave.

17 (a) Burial (b) Date thereof Aug. 14, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Willis Lawrason
(b) Address 4510 Liberty Heights Ave.

AUG 13 1944
(Date filed with Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1944, at 4.45P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16 1943 to Aug. 11 1944, and that I last saw him alive on Aug. 11

Immediate cause of death	Duration
(a) Cerebral Hemorrhage	1 yr.
Due to Generalized Arterio Sclerosis	5 yrs.?
Due to	
Other Conditions - Hypertension Heart Disease	5 yrs.?

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers, M. D.
Address 4108 Liberty Hgts Ave Date signed

Huntington Williams, M.D.

G19833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19833 Registered No. 1358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 E. Lafayette Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 E. Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CELIA MERVIS

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Samuel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1874
8. AGE: Years 70 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Mary
15. Birthplace Russia

16 (a) Informant Julius Mervis - Son
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-44 (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location Pikesville Md & Hamilton Ave
18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto St
19 AUG 13 1944 (Date rec'd by registrar) (c) Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-44 19 , at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1942 to Aug 11 1944, and that I last saw h[illegible] alive on Aug 6 1944.

Immediate cause of death Terminal Bronchopneumonia — Duration

Due to Infected Cyclocele Rectocele

Due to

Other Conditions Uremic Intoxication

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mervis A. Sims M. D.
Address 16 E. Biddle St Date signed 8/12/44

G19834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G19834

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2809 Hilldale Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 Hilldale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ada Crystal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Aaron Friedman
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Rose
15. Birthplace Russia

16 (a) Informant Adolph Brooks
(b) Address 2809 Hilldale ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-13-44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Cem
Location Wash. Blvd.

18 (a) Funeral director Jos. Lewis Inc
(b) Address 1439 E. Balto. St

(a) AUG 13 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1944, at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11- 1944 to 8-12- 1944 and that I last saw h[illegible] alive on 8-12- 1944.

Immediate cause of death: Coronary Occlusion — Duration: 1 day

Due to: Generalized Arteriosclerosis Diabetes Mellitus — 10 yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Solomon Sherman M. D.
Address 2424 Eutaw Place Date signed 8-12-44

SOLOMON SHERMAN

G19835 ✓ G19835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 916 Stoll Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John F Ruff.
3 (b) If veteran, name war
3 (c) Social Security Account No. 220-03-7156

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Edna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1913

8. AGE: Years	Months	Days	If less than one day
30	11	13	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Waiter
11. Industry or business

FATHER
12. Name Joe Ruff
13. Birthplace Hungary

MOTHER
14. Maiden Name Rose Ritz
15. Birthplace Hungary

16 (a) Informant Mrs Edna C Ruff
(b) Address 916 Stoll St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/13/44 (month) (day) (year)
(c) Cemetery or crematory Oakland Cem.
Location Oakland Md

18 (a) Funeral director William M Meeck
(b) Address 213 Light St.

19 (a) Date received by registrar AUG 13 1944 (b) Registrar Baltimore, Md.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12, 1944 at 1:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 19 44 to 8-12 19 44 and that I last saw h[illegible] alive on Aug 12 19 44

Immediate cause of death	Duration
Peritonitis	
Due to Ruptured Appendix	6
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operation: Peritonitis Ruptured Appendix
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Block M. D.
Address Franklin Square Hosp Date signed 8/12/44

G19836 A33689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G19836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Prince Frederick (If outside city or town limits, write RURAL and give town)
(d) Street No. Stakley Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Tyler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-43

8. AGE: Years: 1 | Months: - | Days: - | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Tyler
13. Birthplace Md.

MOTHER
14. Maiden Name Laura ?
15. Birthplace ?

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (month) (day) (year)
(c) Cemetery or crematory Young's Chapel
Location Calvert Co

18 (a) Funeral director P. E. Lusby
(b) Address Prince Frederick Md

19 AUG 14 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944 at 11 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1944 to 8-12 1944 and that I last saw him alive on 8-12 1944

Immediate cause of death: Myocardial insufficiency — Duration: 1 week
Due to: bronchopneumonia — 1 week
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard J. Goenig M. D.
Address Johns Hopkins Hosp Date signed 8-15-44

G19837

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G19837

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 225 Athol Ave
(c) Hospital or institution:
General Gorman Aged People Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Athol Ave. (If rural give location)
Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Eleanor Hoffman

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 4. 1872

8. AGE: Years	Months	Days	If less than one day
72	5	6	..... hr. ..... min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Own home

FATHER
12. Name John H. Hoffman
13. Birthplace Md.

MOTHER
14. Maiden Name Anna M. Adams
15. Birthplace Md.

16 (a) Informant Mr. W. Hoffman
(b) Address 2 Woodsboro, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14. 1944 (month) (day) (year)
(c) Cemetery or crematory St. Peters
Location Libertytown, Md.

18 (a) Funeral director Boyle & Albaugh
(b) Address Woodsboro Md.

19 (a) AUG 14 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10/44. 19.... at 7.50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3/44 19.... to Aug. 10/44. and that I last saw her alive on Aug. 9/44 19....

Immediate cause of death	Duration
Acute Intestinal Toxaemia.	7 days.
Due to	
Due to	
Other Conditions Chronic Cardiac Hypertrophy. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Wade Shaw M.D.
Address 933 Hanover, Date signed 11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19838

YA-88940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

Registered No. G19838

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Jordan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Beaufort

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1909

8. AGE: Years 35 | Months 5 4 | Days 0 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Hospital Worker

11. Industry or business

FATHER
12. Name Nelson Scott
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Scott
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date th Aug 14 44
(month) (day) (year)
(c) Cemetery or crematory Charlottemount
Location Md

18 (a) Funeral director
(b) Address

AUG 14 1944 (d) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/44 19 , at 1.55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24/44 19 , to 8/11/44 19 , and that I last saw h alive on 8/4/44 19

Immediate cause of death: Pulmonary Tuberculosis — Duration: 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Earl R. Kinney M. D.
Address B.C.H. Date signed 8/12/44

G19839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G19839 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 9615 Mary Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen Wirth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-9-1872

8. AGE: Years	Months	Days	If less than one day
72	7	2	hr. min.

9. Birthplace Austria-Hungary (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Jacob Handy
13. Birthplace AUSTRIA-HUNGARY

MOTHER
14. Maiden Name Carolina Bowdino
15. Birthplace Austria-Hungary

16 (a) Informant Mr. John Wirth
(b) Address 3616 Mary Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location

18 (a) Funeral director L. J. Bruch
(b) Address 5302 Harford Rd

19 (a) AUG 14 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 19 44 at 9:10 P M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. K. Wallenmeyer M.D. Medical Examiner.
Date signed Aug. 12, 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19840

G19840

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 31st & Wyman Park
(c) Hospital or institution: U.S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 2 mo. 27 days
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr. 2 mo. 27 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County Jefferson
(c) City or town Millville (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Luther Stunkle

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ida Lenora Stunkle
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) May 22, 1892

8. AGE: Years 52 | Months 2 | Days 21 | If less than one day: hr. min.

9. Birthplace Point of Rocks, Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Wm. Stunkle
13. Birthplace Point of Rocks, Md.

MOTHER
14. Maiden Name Edna Earl
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address U.S. Marine Hospital Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14 44 (month) (day) (year)
(c) Cemetery or crematory U.S. Cemetery
Location Shepherdstown Md.

18 (a) Funeral director Eackles
(b) Address Baltimore Md.

19 (a) [illegible] (b) [illegible] Registrar
(Date received) Washington Williams, M.D. Registrar
AUG 14 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1944, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1943 to Aug. 13 1944, and that I last saw h[illegible] alive on Aug. 12 1944.

Immediate cause of death	Duration
Squamous Cell Carcinoma of Larynx	4 yrs.
Due to	
Due to	
Other Conditions Cervical Metastasis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mark E. Meyers M. D.
Address U.S. Marine Hospital Date signed 7-3-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G19841 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount
(c) Hospital or institution: Church Home and Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Argyle Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Daub

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-23-71

8. AGE: Years 73 | Months 5 | Days 20 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Daub
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden Name Anna Franklin
15. Birthplace Mount Airy, Md.

16 (a) Informant Mr. Peter F. Dwyer
(b) Address 1220 Argyle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem.
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Dickman & Sons.
(b) Address Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 15 AUG 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1944, at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1 19 44, to 8-13 19 44, and that I last saw him alive on 8-13-1944.

Immediate cause of death	Duration
Toxemia	
Due to Tuberculous Pneumonia	?
Due to The E Cavitation	?
Other Conditions Generalized Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: At Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight Hill M. D.
Address Church Home & Hosp. Date signed 8-13-44

G19842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19842 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 Ruskin Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 Ruskin Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY J. CHILDRESS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Florence V.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 27, 1867

8. AGE: Years	Months	Days	If less than one day
77	4	16	hr. min.

9. Birthplace Richmond, Va.
(Town, county, and state)
10. Usual Occupation Stereotype operator
11. Industry or business A. S. Abell Co.

FATHER
12. Name unknown Childress
13. Birthplace Va.

MOTHER
14. Maiden Name unknown
15. Birthplace Va.

16 (a) Informant Mrs. Lola G. Solli
(b) Address 2218 Ruskin Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

AUG 14 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1944, at 54. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19__, to Aug 13 1944
and that I last saw him alive on Aug 11 1944

Immediate cause of death: Coronary Occlusion — Duration 10 wks.
Due to Coronary Arteriosclerosis — 7
Due to Arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herbert Goldstone M. D.
Address 2243 Linden Av. Date signed Aug. 12

G19843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G19843 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2837 WINCHESTER ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 2837 WINCHESTER ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN P BUTLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17-1867

8. AGE: Years 76 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name PATRICK BUTLER
13. Birthplace IRELAND

MOTHER 14. Maiden Name MARY SULLIVAN
15. Birthplace IRELAND

16 (a) Informant MRS JOHN KELLER
(b) Address 2837 WINCHESTER ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-16-44 (month) (day) (year)
(c) Cemetery or crematory ST JOSEPHS CEM
Location TEXAS MD

18 (a) Funeral director Bernard C Hanke
(b) Address 121 E West St

19 AUG 14 1944 (Date rec'd by Registrar) (b) Huntingtown Williams, Md. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 13 1944, at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-31 1941, to 8-13 1944, and that I last saw h Ash alive on 8-13 1944.

Immediate cause of death Arteriosclerotic Heart Disease — Duration 3 yrs.

Due to

Due to

Other Conditions Bronchopneumonia — 11 days

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mary Coleman M. D.
Address 120 Poplar Grove St Date signed 8-13-44

G19844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 126 V

G19844 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address John St & Lafayette Ave
(c) Hospital or institution: Hospital for The Women of Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 346 North Point Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Barbara Haubach

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Mr. Henry Haubach

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 27, 1888

8. AGE: Years 56 Months 6 Days 14 If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name August Frank
13. Birthplace Germany

MOTHER
14. Maiden Name Adelaide — —
15. Birthplace Germany

16 (a) Informant Henry Haubach
(b) Address 346 North Point Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14/44 (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cem
Location Halethorpe

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St

19 (a) AUG 14 1944 (Registrar) (b) Huntington Williams M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10 1944 at 6:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-4 1944 to 8-10 1944 and that I last saw her alive on 8-10 1944.

Immediate cause of death: Peritonitis, acute — Duration 6 Days

Due to Cholangitis, chronic

Due to Cholecystitis, chronic

Other Conditions Cholelithiasis with stones in common duct producing obstruction

(Include pregnancy within 3 months of death)

Date of operation 8-6-44

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature T. E. Russell M.D.
Address Hosp. for Wom. of Md. Date signed 8-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19845 BALTIMORE CITY HEALTH DEPARTMENT G19845
CERTIFICATE OF DEATH 93d Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 907 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 N. Carey St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Annie Gray Cooper

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-69

8. AGE: Years 75 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace St. Marys Co., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Henry Gray
13. Birthplace Md.

MOTHER 14. Maiden Name Rebecca Gray
15. Birthplace Md.

16 (a) Informant Anna H. Boyd
(b) Address 907 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave

19 (a) AUG 14 1944 (Rec'd by registrar) (b) Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/12 1944 at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 15 1944 to Aug 12 1944 and that I last saw her alive on Aug 12 1944

Immediate cause of death Cardiac Vascular disease | Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Watts
Address 515 Linwood Ave Date signed 8/17/44

G19846 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G19846

CERTIFICATE OF DEATH

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 N. Spring St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 N. Spring St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Quickley

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1905

8. AGE: Years 39 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Abraham Quickley
13. Birthplace Md

MOTHER
14. Maiden Name Anna Parks
15. Birthplace Md

16 (a) Informant George Jones
(b) Address 1814 N Spring St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 [illegible] 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) AUG 14 1944 (Date rec'd by Reg.) Hunting for Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 1944, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1944 to Aug 11 1944 and that I last saw h[illegible] alive on Aug 11 1944.

Immediate cause of death: Hypostatic pneumonia
Due to: Acute myocarditis
Due to: Fractured Hip
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
If autopsy:

Duration: 5 days, 1 day

Bruise.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/9
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Aug. 10 1944 at 11 A M
(c) Where did injury occur? Balto. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? [illegible]
(e) Means of injury: Fall down steps

23. Signature Wm. J. Quickley M. D.
Address 1420 E. Chase Date signed Aug 12 '44

Robert L. Graham M.D. for H. Z. Wollenweber M.D.

G19847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19847

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Jordan Alley (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eva Steele

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 59 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Gibson, N. C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Daniel Allbrooks
13. Birthplace N. C.

MOTHER
14. Maiden Name Henna Easterling
15. Birthplace N. C.

16 (a) Informant Edith Cooper
(b) Address 920 Jordan St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Brantley

19 (Date rec'd by registrar) AUG 14 1944 Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Aug. 10, 1944

VS 151

G19848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G19848

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1709 Harlem ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abbie Mariah Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months 73 | Days | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed.

11. Industry or business

FATHER
12. Name Henry Lebkuchler
13. Birthplace Md

MOTHER
14. Maiden Name Isabelle Inman
15. Birthplace Md

16 (a) Informant Mable Whiting
(b) Address 1709 Harlem ave

17 (a) Buried (b) Date thereof 8/14/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Green De. Grace Md

18 (a) Funeral director Ebey O Wilson
(b) Address Hunting Town Maryland

AUG 14 1944
(Date received by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944, at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to Aug 12 1944, and that I last saw h alive on Aug 12 1944

Immediate cause of death
Acute myocardial insufficiency
Due to Carcinoma of Breast
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
1 Day
?
?

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. deLong Leary M. D.
Address 1420 E Chase Date signed Aug 13 44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS 150

G19849

IAGeR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13

Registered No. G19849

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3011 Fisher St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herb Jagers
3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-03-7013
4. Sex M
5. Color or race W.
6 (a) Single, married, widowed, or divorced. W.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 13-1883
8. AGE: Years 61 Months 3 Days — If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Maintenance Man
11. Industry or business Fred Oberdt Co.

FATHER
12. Name Henry Jagers
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Md

16 (a) Informant Dora L. Kinch
(b) Address 3011 Fisher St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or crematory Woodland Pk. Location Parkville Balto Co.
18 (a) Funeral director Wm Cook Jr.
(b) Address 217 E. Lexington St. Baltimore, Md.
19 AUG 14 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1944, at 8 22 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1944 to 8-13 1944 and that I last saw h[illegible] alive on 8/13 1944.
Immediate cause of death Pulmonary Embolism
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Charles B. MacDonald M. D.
Address 1213 Light St Date signed 8-13-44

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G19850 Hypoproteinemia

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50 V

G19850 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1331 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Miss Catherine Magraw

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1884

8. AGE: Years	Months	Days	If less than one day
60	3	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James J. Magraw
13. Birthplace Ireland.

MOTHER
14. Maiden Name Sarah Connelly
15. Birthplace Ireland.

16 (a) Informant Mrs. Margaret Miles
(b) Address 2331 N Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cathedral
Location Baltimore Md

18 (a) Funeral director Wellhorn & Sons
(b) Address 2414 Pond St

AUG 14 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1944, at 7.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 4 1944, to Aug 13 1944, and that I last saw h[illegible] alive on Aug 13 1944.

Immediate cause of death: Cardio-respiratory failure — Duration: 2 Months

Due to Sarcoma of Larynx metastatic to Lungs and Mediastinum — 1 yr

Due to —

Other Conditions Hypoproteinemia and Secondary Anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert F. Berry, M.D.
Address Mercy Hospital Date signed 8/13/44

G19851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G19851 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 6000 Bellona Ave.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Fork (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie J. Salisbury

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edwin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1870

8. AGE: Years 73 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace September 13 1870 (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edwin Teal
13. Birthplace New York U.S.

MOTHER
14. Maiden Name Malinda Lorhr
15. Birthplace New York U.S.

16 (a) Informant Marchant Salisbury
(b) Address 755 Montford St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East North Ave. Ext.

18 (a) Funeral director William Cosby Son
(b) Address 1217 St Paul St.

AUG 14 1944 (Date received by Registrar) Washington for Williams, M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1944, at 12.10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1942 to Aug 11 1944 and that I last saw her alive on Aug 11 1944

Immediate cause of death: Duration
(a) Cerebral Hemorrhage — Sudden
Due to
Due to
Other Conditions: Carcinoma of Uterus — Study
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. A. Richardson M. D.
Address 117 W. 25th St. Date signed Aug 14 44

G19852 Roland Ave Baltimore 21 Md.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19852 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Deepdene Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Deepdene Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise W. McCosh.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19. 1859

8. AGE: Years	Months	Days	If less than one day
84	8	13 23	hr. min.

9. Birthplace Mass.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Charles M. Kellogg
13. Birthplace Unknown

MOTHER
14. Maiden Name Margaret S. Kennedy
15. Birthplace N. J.

16 (a) Informant James N. McCosh.
(b) Address 1123 N Eutaw

17 (a) Private Cremation (b) Date thereof 8/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

19 AUG 14 1944 (Signature) Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12- 1944, at 3 20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1944 to Aug 12 1944, and that I last saw h[er] alive on Aug 12 1944.

Immediate cause of death Hyperpyrexia — Duration 24 hours

Due to Old Arteriosclerosis — 5 Days

Due to Hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Gibson Porter, M.D.
Address 1 E Eager St Baltimore Md Date signed 8/13/44

G19853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

G19853

Registered No.

78 #51727

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 yrs. 3 mos. 23 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1566 Ridgely St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Snow Ricker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edward (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 2, 1866

8. AGE: Years 78 | Months -6- 7 | Days -8- | If less than one day hr. min.

9. Birthplace New Orleans, La. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name John Walters

13. Birthplace Germany

MOTHER — 14. Maiden Name Mary Kenney

15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8.14.44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Anne Arundel County Md

18 (a) Funeral director Millburn Coffin Co.

(b) Address 1219 E. Pont St

(c) Filed AUG 14 1944 Registrar Millburn, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1944 at 2:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 17, 1938, to Aug. 10, 1944, and that I last saw her alive on Aug. 10, 1944.

Immediate cause of death: Bronchopneumonia — Duration: 3 days

Due to

Due to

Other Conditions: Pyelonephritis generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature D. M. Phillippi M. D.

Address Balt. City Hosp. Date signed 8-13-44

G19854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19854

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1248 E. North Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1248 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM PETER BRAUN

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dorothea F. Braun
6 (c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) June 30, 1873

8. AGE: Years	Months	Days	If less than one day
71	1	11	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Musician - ret. 3 yrs
11. Industry or business City Park Band

FATHER
12. Name Conrad Braun
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Hienzerling
15. Birthplace Germany

16 (a) Informant Mrs. Dorothea F. Braun
(b) Address 1248 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryand

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway, 13

19 (a) AUG 14 1944
Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION 9.10 A. M

20. DATE OF DEATH Aug. 11, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Aug 11 1944, and that I last saw h.. alive on Aug 10 1944.

Immediate cause of death
Uremia
Due to Chr. Nephritis
Due to
Other Conditions Gen. Arteriolosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
>
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lowell Braun M. D.
Address 1261 E North Date signed 8/12/44

G19855

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126 Registered No. G19855

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 E. North Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN WILLIAM FRIES

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 212-01-2311

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lula JohnFries
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) May 17, 1881

8. AGE: Years 63 | Months 12 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Lucas Bros. Ret. 2 yrs.

FATHER
12. Name Conrad Fries
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Cramer
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Edward W. Fries
(b) Address 2203 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) ... (b) ... (Date received by Registrar) (Registrar)

AUG 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1944, at 1.29 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1944 to 8-11 1944, and that I last saw h alive on Aug 11 1944.

Immediate cause of death: Generalized Peritonitis
Due to: Ruptured Gall Bladder
Due to: Empyema Cholecystitis & Cholelithiasis & Jaundice
Other Conditions: duct stone

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Abscess
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Baltimore M. D.
Address East Baltimore Funeral Home Date signed 8-11-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G19856 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 N. Bulver St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 N. Bulver St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Augusta Kuehn

3 (b) If veteran, name war no

3 (c) Social Security Account No. no

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Gustav Kuehn 6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) May 7, 1874

8. AGE: Years 70 | Months 3 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name August Milke
13. Birthplace Germany.

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Gustav Kuehn
(b) Address 40 N. Bulver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick ave.

18 (a) Funeral director Mrs. Nus. John F. Treufel & Son
(b) Address 801 W Fayette St

AUG 14 1944 (Date rec'd by registrar) (b) H. E. [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1944 at 3 15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June. 21 44 19 to Aug, 11 1944. and that I last saw her alive on Aug. 11 19 44.

Immediate cause of death Diabetes Mellitus. — Duration 1 yr

Due to

Due to

Other Conditions Myocarditis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide D
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature V. Lloyd Johnson M. D.
Address Catonsville, Md. Date signed 8/14/44

G19857

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93 D

G19857 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1109 Mount ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1893

8. AGE: Years 50 51 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Lancaster Co., Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wesley Rook
13. Birthplace Lancaster Co. Va.

MOTHER
14. Maiden Name Olivia Nutt
15. Birthplace Lancaster Co. Va.

16 (a) Informant John Rock (brother)
(b) Address 1109 Mount St

17 (a) Burial (b) Date thereof Aug 15-1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Brooklyn

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St

19 (a) (Date received by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944, at 2 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fraley M.D.
Medical Examiner.
Date signed Aug. 13 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

G19858 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3319 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wallace M Lookingland

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-3735

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Dorothy Lookingland

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Sept 13 1898

8. AGE: Years 45 | Months 10 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Western Md Dairy

FATHER
12. Name David Lookingland
13. Birthplace Balto

MOTHER
14. Maiden Name Jennie Wilkinson
15. Birthplace Balto

16 (a) Informant Dorothy Lookingland
(b) Address 3319 E Balto St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 1944 (month, day) (year)

(c) Cemetery or crematory Western Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004 E Baltimore St

19 (a) [illegible] (b) [illegible]

AUG 14 1944 for Wallace, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944 at 5 42 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-44 to 8-12-44 and that I last saw h[illegible] alive on 8-9 1944

Immediate cause of death CORONARY OCCLUSION — Duration 1 YR.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony F Barone

Address 524 York Rd Date signed 8/15/44

G19859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G19859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 89 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Westerna Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Edward A. Huber

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Alette Huber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 - 1854

8. AGE: Years	Months	Days	If less than one day
89	7	21	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Night Clerk

11. Industry or business Penny Rail

FATHER
12. Name Dont Know
13. Birthplace Germany

MOTHER
14. Maiden Name Dont Know
15. Birthplace Germany

16 (a) Informant Mrs Mable J Schmidt
(b) Address 3207 Westerna Ave

17 (a) Burial (b) Date thereof Aug. 16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Rural

18 (a) Funeral director Wellsville Funeral Home
(b) Address 2004 E. Orleans St

19 (a) Aug 14 1944 (b)
(Date received by registrar) Registrar's No.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1944, at 10:5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1944, to 8-14 1944, and that I last saw him alive on 8-14 1944.

Immediate cause of death Bronchopneumonia — Duration 1 Day

Due to

Due to

Other Conditions Benign Prostatic Hypertrophy
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John S Black M. D.
Address Franklin Sq Hosp Date signed 8/14/44

Medical Williams M.D.

G19860 BALTIMORE CITY HEALTH DEPARTMENT ✓ G19860

CERTIFICATE OF DEATH 54B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1243 Williams St.
(c) Hospital or institution:
So. Balto. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 William St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME William. W. Franckowski FRANCKOSKI

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/36

8. AGE: Years 7 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Jr School

11. Industry or business

FATHER
12. Name JAMES V. Franckowski
13. Birthplace Balto.

MOTHER
14. Maiden Name Mildred Wilkinson
15. Birthplace Md.

16 (a) Informant Mrs. J. V. Franckoski
(b) Address 1243 Williams St

17 (a) Burial (b) Date thereof 8/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dashmore
Location E. Northern

18 (a) Funeral director J. J. Daley & Sons
(b) Address 139 E. Eight St.,

19 (a) AUG 14 1944 Huntington, Indiana, Md.
(Date filed in Registrar's office) (b) Address

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12-44, 19..., at 2 40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 27 19 44 to 8-12- 19 44 and that I last saw him alive on 8-12- 19 44

Immediate cause of death Medulla - Blastoma — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Burst M.D.
Address 1211 Eight St Date signed 8-12-44
M. D.

G19861 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51

Registered No. G19861

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2008 W. Fayette St
(c) Hospital or institution: No

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2008 W. Fayette St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John F. Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-5367

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma Langdorf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 6, 1870

8. AGE: Years	Months	Days	If less than one day
73	9	5	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Western Bakery

FATHER
12. Name Frederick Schwartz
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth List
15. Birthplace Balto.

16 (a) Informant Mrs. Emma L. Schwartz
(b) Address 2008 W. Fayette St

17 (a) Burial (b) Date thereof Aug-14-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Wittstadt
(b) Address 1101 E Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 14 1944

Herrington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 24, 1944, to Aug. 11 1944 and that I last saw him alive on Aug. 11, 1944

Immediate cause of death: Carcinoma of Prostate — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George A. Kupp M.D.
Address 3030 Edmondson Ave. Date signed 8/12/44

G19862

HEALTH DEPARTMENT—CITY OF BALTIMORE

G19862

CERTIFICATE OF DEATH

1310

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Lyman ave St., 12 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 73 yrs. 5 mos. 6 ds. If not living in Balto. If of foreign birth? yrs. mos. ds.

2. FULL NAME William Chester Sederberg

If U. S. Veteran specify WAR

(a) Residence: No. 402 Lyman ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of: Sally Thorn Sederberg

6. DATE OF BIRTH (month, day, year): March 6, 1871

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Physician

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year): 1928

11. Total time (years) spent in this occupation: 50

12. BIRTHPLACE (city or town) (State or country): Baltimore City Md

FATHER

13. NAME: Charles A. Sederberg

14. BIRTHPLACE (city or town) (State or country): Balto. City

MOTHER

15. MAIDEN NAME: Mary Eaton

16. BIRTHPLACE (city or town) (State or country): Martinsburg, W. Va.

17. INFORMANT: Wife
(Address): 402 Lyman ave

18. BURIAL, CREMATION, OR REMOVAL
Place: London Pk. Date: 8/15/44 19

19. UNDERTAKER: Harry H. Nuttle
(Address): 1301 E. Lanvale Ave

20. FILED 19 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Aug. 12, 1944

22. I HEREBY CERTIFY, That I attended deceased from June, 1944, to Aug 12, 1944

I last saw him alive on Aug 12, 1944. Death is said to have occurred on the date stated above, at 6:10 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardio Renal disease	1928
Other contributory causes of importance: Hypertension, arteriosclerosis	

Was an operation performed? no Date of

For what disease or injury? —

Name of operation —

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Lyman Abbott M. D.

(Address) 3939 Greenmount Ave

WHITE FORMS. PRINT ONLY. USE INK. THIS IS ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V8 3

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

File G19863 86925

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13

Registered No. G19863

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mo. 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Etting St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Howard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Seperated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29, 1914

8. AGE: Years	Months	Days	If less than one day
29	8	11	hr. min.

9. Birthplace Florida (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Lonnie Church
13. Birthplace Ga.

MOTHER
14. Maiden Name Mollie ?
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Lord. H. Holland
(b) Address 108 Druid Hill Ave.

19 (a) (Date rec'd by registrar) AUG 14 1944 (b) Huntington, Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10th, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1/44 19 , to 8/10/44 19 , and that I last saw h[illegible] alive on 8/10/44 19 .

Immediate cause of death Pulmonary Tuberculosis — Duration ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul R. Kinney M. D.
Address B. C. H. Date signed 8/12/44

G19864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 154

G19864 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where not applicable write NONE. Do not abbreviate. Use no ditto marks. Be sure to answer each question. Do not leave any blanks. Be particular to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 918 N. Eutaw St.

(c) Hospital or institution: Lutheran Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min

(e) Length of stay in Baltimore (yrs., mos., or days) 15 min

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)

(d) Street No. 915 S. Charles St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Bleekman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			hr. 15 min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Mac Bleekman

13. Birthplace Balt. Md.

MOTHER 14. Maiden Name Pauline Eisner

15. Birthplace Balt. Md.

16 (a) Informant Mrs. Bleekman

(b) Address 915 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (month) (day) (year)

(c) Cemetery or crematory Druedale

Location

18 (a) Funeral dir. Jos. Levin Inc

(b) Address 1900 E. Balto. St

19 (a) (Date rec'd by registrar) (b)

VS-180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1944, at 10:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1944 to 8-13 1944, and that I last saw him alive on 8-13 1944

Immediate cause of death	Duration
Prematurity.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address 211 Lyndhurst Rd Date signed 8-14-44

G19865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83d

G19865 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3014 Wylie Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Wylie Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Ryan Ryan,

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-05-4287

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida. R. Ryan
6 (c) If alive, give age --years

7. Birth date of deceased (mo., day, yr.) June 25, 1893

8. AGE: Years	Months	Days	If less than one day
51	1	16	hr. min.

9. Birthplace Baltimore City,
(Town, county, and state)
10. Usual Occupation Plumber,
11. Industry or business Ship Yard,

FATHER
12. Name Louis B. Ryan,
13. Birthplace Baltimore City,

MOTHER
14. Maiden Name Mary Dempsey,
15. Birthplace Ireland,

16 (a) Informant Mrs. Ida R. Ryan,
(b) Address 3014 Wylie Ave.

17 (a) Burial (b) Date thereof 8/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral,
Location Baltimore City,

18 (a) Funeral director B. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 AUG 14 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11 44, at 12.30P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1942 to 8/11 1944, and that I last saw h Im alive on 8/11/ 1944

Immediate cause of death Hemiplegia (right side) — Duration 2 Days

Due to Hypertension

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James L. Lehmberger M. D.
Address Medical Arts Bldg. Date signed 8/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19866

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G19866

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 714 E. 21st Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 714 E. 21st Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mrs. Nannie Gertrude Holland

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Edward Hudson Holland
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 28-1878

8. AGE: Years 66 | Months 5 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER — 12. Name James F. Robey
13. Birthplace Virginia

MOTHER — 14. Maiden Name Annie E. Franks
15. Birthplace Virginia

16 (a) Informant Mrs. Ethel L. Rhodes
(b) Address 2636 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) ..... (Date rec'd by registrar) (b) Huntington, Md.

VS 180 AUG 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944 at 1:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1944 to Aug 12 1944; and that I last saw her alive on Aug 12 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Chronic Obstructive Jaundice	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Jack J. Singer
Address 506 E. North Ave Date signed 8-15-44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19867

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G19867

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1204 Eoz Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Eoz Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Marston, Jr.

3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-16-7025

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20-1923

8. AGE: Years 21 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation
11. Industry or business Farm Dairy

FATHER
12. Name Charles E. Marston
13. Birthplace Virginia

MOTHER
14. Maiden Name Eloise V. Palmer
15. Birthplace Maryland

16 (a) Informant Charles E. Marston
(b) Address 1204 Eoz Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15-1944 (Month) (day) (year)
(c) Cemetery or crematory St. Marys (Hampden)
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) AUG 14 1944 (Date rec'd by registrar) Registrar Huntington for Milwaukie, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12- 1944, at 7.40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1942 to 8-12 1944, and that I last saw h. l. M. alive on 8-12 1944.

Immediate cause of death
Uremia — Duration 2 wks

Due to Hypertensive CVD & Chronic Nephritis — ?

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence J. Schumann M. D.
Address 3711 Falls Rd Date signed 8-14-44

G19868 (3) BALTIMORE CITY HEALTH DEPARTMENT ✓ G19868

CERTIFICATE OF DEATH 1244 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1276 Riverside Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or ~~town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1276 Riverside Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel A. Simpson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Warren W. Simpson

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) November 29-1893

8. AGE: Years 50 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name Stephen B. Hill
13. Birthplace Cecil Co. Md.

MOTHER
14. Maiden Name Estella A. Canpore
15. Birthplace Baltimore Md.

16 (a) Informant Warren W. Simpson
(b) Address 1276 Riverside Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Flynn & Flanigan
(b) Address 1476 Light St.

19 (a) AUG 14 1944 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 — 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1944 to Aug 10 1944, and that I last saw h[illegible] alive on Aug 10 1944.

Immediate cause of death Hypostatic Pneumonia — Duration 2 days.

Due to Symptoms of Uremia. — 6 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ~~Ind~~

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Bernhardt M.D.

Address 1279 Milliam N Date signed 8/12/44 M. D.

C19869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56b

Registered No. C19869

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 Edmondson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Edmondson
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Bradford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John . Bradford Sr.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12. 1909

8. AGE: Years 35 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Kentucky U.S.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jerry J. Davis
13. Birthplace U S

MOTHER
14. Maiden Name Linda Dorsey
15. Birthplace U S

16 (a) Informant John . Crawford
(b) Address 1310 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 15 44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) AUG 14 1944 (Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11- 1944, at 5 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1944 to 8/11 1944, and that I last saw him alive on 8-10 1944.

Immediate cause of death: Coronary Thrombosis
Due to: Arteriosclerosis
Due to:
Other Conditions: Diabetes Pulmonary Edema
(Including pregnancy within 3 months of death)
Date of operation: Negative
Major findings of operation:
of autopsy:

Duration: Days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature
Address 600 Washington Blvd. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G19870

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3669 Ash St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3669 Ash St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Guy R. Johnson

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Ist. World War	215 09 3569	Male	White	Married

6 (b) Name of husband or wife Mary F. Johnson
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Mar. 20; 1885

8. AGE: Years	Months	Days	If less than one day
59	4	21	hr. min.

9. Birthplace Kansas
(Town, county, and state)
10. Usual Occupation Retired Operator
11. Industry or business Balto. Transit Co

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mary F. Johnson
(b) Address 3669 Ash St

17 (a) Burial (b) Date thereof Aug 14; 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.
18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 AUG 14 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 10; 44 19 at 5.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1942 to Aug. 10 1944 and that I last saw h[illegible] alive on Aug. 10 1944.

Immediate cause of death	Duration
Cardiac decompensation	5 years
Due to Coronary thrombosis	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. H. Krenzer M. D.
Address 402 E. Lamvale St. Date signed 8-12-44

19871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G19871

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga - Balto
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4303 Forth hill Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Leopold Hammersbough

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-20-5795

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bertha Hammersbough
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Feb. 16, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	27	— hr. — min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Stock Clerk
11. Industry or business Kresge 5-10¢ Store

FATHER
12. Name Simon Hammersbough
13. Birthplace Germany

MOTHER
14. Maiden Name Caroline Adler
15. Birthplace Germany

16 (a) Informant Leopold Hammersbough
(b) Address 4303 Forth Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 14/44 (month) (day) (year)
(c) Cemetery or crematory Chesterfield Cemetery
Location O'Donnell St

18 (a) Funeral director J. Arens & Co
(b) Address 2437 Eastern Ave

19 (a) Registrar (b) AUG 14 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944, at 12 05 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1944, to Aug 12 1944, and that I last saw him alive on Aug 12 1944.

Immediate cause of death	Resp. Failure	
Due to	Coronary Thrombosis	Several days
Due to	Myocardial damage	?
Other Conditions	—	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations: —
of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Ellsworth Cook Jr. M. D.
Address Mercy Hosp Date signed 8-14-44

DOA
A36513 G19872

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G19872
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 935 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina Austin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 1 | Months 208 | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Austin
13. Birthplace ?

MOTHER
14. Maiden Name Marie ?
15. Birthplace ?

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Aug 14 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Keyesville Va.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Caroline St

19 (a) AUG 11 1944 (b) Huntingtown Williams, M.D.
(Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 8 1944, to August 12 1944, and that I last saw h alive on 8-12-1944

Immediate cause of death: Respiratory failure — Duration

Due to: Double pneumonia

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp. Date signed 8-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G19873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G19873 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 913 Rutland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Rutland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Hammond

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife. Allen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 2, 915

8. AGE: Years	Months	Days	If less than one day
29	5	10	hr. min.

9. Birthplace Farmerville Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Evans
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Wyer
15. Birthplace Va.

16 (a) Informant Allen Hammond
(b) Address 913 Rutland Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug 14/44 (month) (day) (year)
(c) Cemetery or crematory
Location Farmville Va.

18 (a) Funeral director Mrs. Robert G. Elliott Dgt.
(b) Address 1229 E. Caroline St

19 (a) AUG 14 1944 (b)
(Date rec'd by registrar)

Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-12 1944 at 1-P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1944 to 8-12 1944 and that I last saw h. alive on 8-12- 1944

Immediate cause of death Lobar Pneumonia

Due to Exposure to Cold

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration 4 D

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J H Walters M. D.
Address 2174 McCulloh Date signed 8/13/44

Huntington Pollitzer, M.D.

G19874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1194

Registered No. G19874

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Greenhaven (If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena P.O. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John M. Abend

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1943

8. AGE: Years	Months	Days	If less than one day
1	0	10	27 hr. min.

9. Birthplace Maryland (Baltimore) (town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Carl G. Abend
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name Catherine E. Heuer
15. Birthplace Maryland (Balto.)

16 (a) Informant Mrs. Catherine E. Abend (mother)
(b) Address Greenhaven, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 15, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location B. A. Car Rt.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 E. Chase St. (30) Huntington Williams Ave

19 AUG 14 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1944, at 10:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9 P.M. 8/12/1944 to Death 19..., and that I last saw him alive on 8/12/1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Broncho-Pneumonia	2 Days
Due to Diarrhea & Dehydration	2 Days
Other Conditions Hyperpyrexia	5 hrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dean Pearlman, M. D.
Address Univ. Hospital Date signed 8/12/44

G19875 BALTIMORE CITY HEALTH DEPARTMENT ✓ G19875
CERTIFICATE OF DEATH 83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. b
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Meta Clay

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. (M)

6 (b) Name of husband or wife Willie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2 - 1891

8. AGE: Years 53 yr. | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Keeper.

11. Industry or business

FATHER 12. Name Jack Rowe

13. Birthplace Va.

MOTHER 14. Maiden Name Julia ?

15. Birthplace Va.

16 (a) Informant Jack Cheatham

(b) Address 1307 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-44 (month) (day) (year)

(c) Cemetery or crematory Crew Va.

Location

18 (a) Funeral director Wm Robert Elliott & Dgt

(b) Address 1129 N. Caroline St.

19 AUG 14 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944, at 4:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage
spontaneous

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gratz M.D.
Medical Examiner.
Date signed Aug 13 1944

G19876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G19876 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Cathedral St
(c) Hospital or institution: (Seven apts)
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 701 Cathedral St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert Thorndike Tiffany

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Harriet Townsley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1861

8. AGE: Years 82 Months 8 Days 27 If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER 12. Name Geo P. Tiffany

13. Birthplace Mass.

MOTHER 14. Maiden Name Anne Dickey

15. Birthplace Mass.

16 (a) Informant C Wyatt Tiffany

(b) Address 101 W. Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16 44 (month) (day) (year)

(c) Cemetery or crematory Green Mount

Location Balto Md

18 (a) Funeral director Henry Watkins Sons

(b) Address McCulloh & Madison Sts

19 (a) (Date received by Registrar) (b) Registrar

AUG 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1944, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1944, to Aug 13 1944, and that I last saw him alive on Aug 13 1944.

Immediate cause of death — Duration

Cerebral Vascular Accident — 6 days

Due to Cerebral Arteriosclerosis — unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Francis W Gluck M.D.

Address 715 Park Ave Date signed 8/14/44

G19877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a ✓

G19877 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 718 S. Lakewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charley Kurek

3 (b) If veteran, name war: W.W.#1 W.W.#2

3 (c) Social Security Account No. 216 16 3422

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR. 10 1898

8. AGE: Years 46 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace BALTIMORE (Town, county, and state)

10. Usual Occupation BOILER FIREMAN

11. Industry or business

FATHER
12. Name WILLIAM KUREK
13. Birthplace GERMANY

MOTHER
14. Maiden Name AGNES STASIAK
15. Birthplace GERMANY

16 (a) Informant MARTHA RIDINGER (SISTER)
(b) Address 525 N. BELNORD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 15/44 (month) (day) (year)
(c) Cemetery or crematory U.S. NATIONAL
Location FREDERICK AVE.

18 (a) Funeral director Lily Zerbe Chas
(b) Address 403 S. WOLFE ST.

19 AUG 14 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1944 at 4 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed August 13 1944

G19878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G19878 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland The Cold Spring Home
(b) Street address 2101 W Coldspring Lane
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
Street No. 14 E Hill st (if rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William L Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace —

MOTHER
14. Maiden Name [illegible] Sanford
15. Birthplace 41 [illegible]

16 (a) Informant Mrs. Josephine Sanford
(b) Address 91

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/15/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director William M Marsch
(b) Address 715 Light St

AUG 14 1944 (a) Signature of local registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 11 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 31 1941 to Aug 11 1944, and that I last saw h[illegible] alive on July 7 1944.

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions Bronchial Asthma

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Patterman M.D.

Address 2324 Reisterstown Rd Date signed 8/12/44

G19879 Raub ✓ G19879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution:
Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Raub

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widower

6 (b) Name of husband or wife Adam
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Daily
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Fitzpatrick
15. Birthplace Ireland

16 (a) Informant Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16. 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Rita Windsfeld
(b) Address 914 Gramercy Drive

19 (a) Date of registration AUG 14 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1944, at 9 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1944 to Aug 13 1944 and that I last saw h alive on Aug 12-1944

Immediate cause of death: Lobar Pneumonia — Duration 5 days
Due to: Chr Nephritis
Due to: Chr Myocarditis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Otto H. Duker
Address 928 E. North Ave Date signed 8/14/44 D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19880

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G19880 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widower

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years	Months	Days	If less than one day
79			hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Ferdinand Genstre
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Cuslatt
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rela Wiedefeld
(b) Address 914 Greenmount Ave

AUG 14 1944 (Date filed by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION 10 p.m

20. DATE OF DEATH August 12 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1944 to Aug 12 1944, and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	4 days
Due to Hypertension	7 yrs
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? None (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Adolf Decker
Address 928 E. North Ave Signed 8/14/44

Huntington Williams, M.D.

G19881

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G19881
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 Boston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick J. Cannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1898

8. AGE: Years	Months	Days	If less than one day
45	8	29	hr. min.

9. Birthplace Mass
(Town, county, and state)

10. Usual Occupation Clerk
11. Industry or business U.S. Gov't.

FATHER
12. Name James Cannon
13. Birthplace Mass.

MOTHER
14. Maiden Name Nellie Sullivan
15. Birthplace Mass.

16 (a) Informant Miss Mary Cannon (sister)
(b) Address 2547 17th St. NW Wash. D.C.

17 (a) Burial (b) Date thereof 8-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Washington D.C.

18 (a) Funeral director Spalding Sullivan
(b) Address 3821 14th St. NW Washington D.C.

AUG 14 1944
(Date rec'd by Registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944, at 3:20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert Lee Feaster M.D.
Medical Examiner.
Date signed August 14, 1944

G19882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G19882

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 S. Calverton Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Calverston Road
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret Geiger

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Melchior Geiger

6 (c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) February 24 1867

8. AGE: Years 77 | Months 5 | Days 24 | If less than one day: 3 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Francis Casper Hunder
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth B. Schmittner
15. Birthplace Germany

16 (a) Informant Melchior Geiger
(b) Address 131 S. Calverton Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George E. Schwab
(b) Address 210 Frederick Ave.

19 (a) AUG 15 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1944, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15 1944, to 8/14 1944, and that I last saw her alive on 8/12 1944.

Immediate cause of death	Duration
Cirrhosis of the Liver	3 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James L. Shaffer M. D.
Address 1946 W. Balto Date signed 8/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19883

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hospital
(c) Hospital or institution: Fayette + Pulaski Streets
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 S. Addison Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Dressel

3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept. 1 1943
8. AGE: Years 1 Months 11 Days 13 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Earl Dressel
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Theresa Zentgraf
15. Birthplace Balto., Md.

16 (a) Informant Earl Dressel
(b) Address 106 S. Addison Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Leo V. Schuerholz
(b) Address 2101 Frederick Avenue

19 AUG 15 1944 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1944, at 9:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1944 to 8/17 1944 and that I last saw h[illegible] alive on 8/17 1944

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to Pertussis — Duration 5 wks

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edmund Cooper M.D.
Address 1 W. Saratoga St. Date signed 8/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G19884

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 Wynoake Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Wynoake Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Thomson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Retired Grocer
11. Industry of business

FATHER
12. Name A. Thomson
13. Birthplace Scotland

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Miss K. Thomson
(b) Address 525 Wynoake Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem
Location Mary J. Wiedefeld

18 (a) Funeral director Mary T. Wiedefeld
(b) Address 501 E. 22nd Street

19 AUG 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13th 1944, at 3:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Aug 13 1944, and that I last saw him alive on Aug 12 1944.

Immediate cause of death	Duration
Coronary thrombosis	
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack J. Singer
Address 506 E. Monument Date signed 8-14-44 M. D.

G19885844
A32844

BALTIMORE CITY HEALTH DEPARTMENT X V
CERTIFICATE OF DEATH 128

G19885
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Roanoke (If outside city or town limits, write RURAL and give town)
(d) Street No. 715 Richelieu Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Van Dorsten

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Child

6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-31-42

8. AGE: Years	Months	Days	If less than one day
2	0	14	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name J. W. Van Dorsten
13. Birthplace Holland

MOTHER
14. Maiden Name Elizabeth Jones
15. Birthplace Va

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/15/44 (month) (day) (year)
(c) Cemetery or crematory
Location Roanoke Va

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penny. aves.

19 (a) AUG 15 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944 at 6 3/4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-26- 1944 to 8-14- 1944, and that I last saw alive on 8-14- 1944

Immediate cause of death	Duration
Convulsion	
Due to Pyrexia	
Due to Cushing Syndrome	
Other Conditions Lung Tumor.	

(Include pregnancy within 3 months of death)
Date of operation 7-31-44
Major findings of operation: Pancreatitis Hepatomegaly
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth B. Hinckley, M. D.
Address Johns Hopkins Hosp. Date signed 8-14-44

G19886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G19886 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Temple Gardens Apts (If rural give location) Madison Ave & Glendale Rd.
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pinkney Lazarus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Rhoda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Bernard
13. Birthplace

MOTHER
14. Maiden Name Minnie
15. Birthplace

16 (a) Informant Mrs M. Rosenbloom
(b) Address Temple Garden Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-44 (month), (day), (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Balto. St

19 (a) (Date received) AUG 15 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13-1944, at 6:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Aug 13 1944, and that I last saw h alive on Aug 13 1944.

Immediate cause of death — Duration
Acute Cardiac Dilat — hr.
Acute Pul. Edema —
Due to — Arteriosclerosis —
Due to Cardiac insuff
Hypertension.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr Bernard J Cohen M. D.
Address Marlborough Date signed 8-14-44

G19887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

G19887 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9 5
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Independent St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Cecelia Oreber

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-27

8. AGE: Years	Months	Days	If less than one day
17	6 5	11 15	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name William H. Oreber
FATHER 13. Birthplace Balto
MOTHER 14. Maiden Name Estelle Guerke
MOTHER 15. Birthplace Balto
16 (a) Informant hosp. records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral Cem.
Location Baltimore
18 (a) Funeral director Mamie Cook Lyfer
(b) Address 1600 N. North Ave
19 (a) (b) (Date received by Registrar) (Registrar)
AUG 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13 1944 at 8:05 A M
21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1944 to 8-13 1944 and that I last saw her alive on 8-13 1944

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic Ht. disease, Aortic + mitral insufficiency & stenosis	? 10 yrs
Due to	
Other Conditions Diphtheria carrier	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp. Date signed 8-14

G19888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 1312

G19888 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 George
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 George
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Biddle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1902

8. AGE: Years 42 | Months 7 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Nicolas Biddle
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Thomas
15. Birthplace Md.

16 (a) Informant Emma Biddle
(b) Address 509 N. Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. City

18 (a) Funeral director Samuel H. Chappelear
(b) Address 638 N. Fulton Ave.

19 (a) ..... (b) .....
(Date received by local registrar) (Registrar)

AUG 15 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1944, at 5.38 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944, to Aug 13 1944, and that I last saw h.... alive on Aug 13 1944

Immediate cause of death: Chr. Hypertension
Chr. Nephritis
Due to Pulmonary Tuberculosis

	Duration
Chr. Hypertension	1 year
Chr. Nephritis	1 year
Pulmonary Tuberculosis	1 yr.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Wm. L. Berry M. D.
1420 E. Chase Date signed Aug 14 '44

G19889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G19889

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. H.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 120 W. 22nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Columbus Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-18-7729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace Cheraw S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Ind. Dry Docks

FATHER
12. Name Columbus Thomas
13. Birthplace S. C.

MOTHER
14. Maiden Name Annie Broadie
15. Birthplace S. C.

16 (a) Informant Howard Thomas
(b) Address 120 W. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-44 (month) (day) (year)
(c) Cemetery or crematory Zion
Location Cheraw S. C.

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 1 Fillmore St. Washington Village, Md.

19 (a) (Date rec'd by registrar) AUG 16 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1944, at 2 40 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Puncture slab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 13 1944 2 15 P.M.
(b) Where did injury occur? 118 W. 22nd St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury stabbed w ice pick

23. Signature Robert Lee Fentam M.D. Medical Examiner.
Date signed August 13 1944

G19890 MAGITTI

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19890 1226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hosp
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balt Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3508 E. Pratt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Andrew Magitti.
3 (b) If veteran, name war
3 (c) Social Security Account No. 213-07-7659

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W-	

6 (b) Name of husband or wife Laura
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16 1889

8. AGE: Years	Months	Days	If less than one day
54	7	27	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Marino Magitti
13. Birthplace Italy

MOTHER
14. Maiden Name Matilde Menardi
15. Birthplace Italy

16 (a) Informant Laura Magitti (Wife)
(b) Address 3808 E. Pratt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

AUG 15 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13/1944 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/24 1944 to 8/13 1944 and that I last saw h alive on 8/13 1944

Immediate cause of death	Duration
Hemorrhage Stroke.	
Due to Head - Subdural	
Due to	
Other Conditions Interstitial adhesions.	

(Include pregnancy within 3 months of death)
Date of operation 8/11/44
Major findings of operation: adhesions Sigmoid to lateral wall
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter J. Jaworski
Address 1a Legal Dept Date signed 8/13/44
Walter J. Jaworski

G19891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G19891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 Eastern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 Eastern ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME AGNES - ZIELINSKA

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Married

6 (b) Name of husband or wife Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1890

8. AGE: Years	Months	Days	If less than one day
53	8		hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Peter Kozyzelniak
13. Birthplace Poland

MOTHER
14. Maiden Name Dora Barczak
15. Birthplace Poland

16 (a) Informant Michael Zielinski
(b) Address 2018 Eastern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Balto.

18 (a) Funeral director W. L. Fialkowski
(b) Address 2007 Eastern Ave

AUG 15 1944 Huntington Williams M.D. (Date Rec'd by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1944, at 6 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944, to Aug 14 1944, and that I last saw her alive on Aug 13 1944

Immediate cause of death Diabetic Coma — Duration 48 hrs

Due to Diabetes - Cardio-vascular Disease — Duration ?

Due to — Duration 2 wks.

Other conditions Gangrene of leg in hospital for 2 wks

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.

Address 2007 E. Balto Date signed Aug 14 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

19892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G19892

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 Reservoir st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Reservoir St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella V. Daniels

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) ~~Single, married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband Charles Daniels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 19th 1872

8. AGE: Years	Months	Days	If less than one day
72	4	25	hr. min.

9. Birthplace Charlotte N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

MOTHER / FATHER
12. Name (Unknown) Murphy
13. Birthplace Unknown
14. Maiden Name "
15. Birthplace "

16 (a) Informant Henry Daniels
(b) Address 426-21st N.W. Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44
(month) (day) (year)
(c) Cemetery or crematory Oak dale
Location N. C.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

AUG 15 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14th 1944, at 7½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1944, to Aug 14 1944, and that I last saw her alive on Aug 14 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	6 days
Due to Arterio-Sclerosis Hypertension	Several
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. H. Moody
Address 1403 Park Ave Date signed 8/15/44

G19893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G19893
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Canyon Court & Dukeland St
(c) Hospital or institution: West Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Deborah D. Johns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John S. Johns
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1st 1866

8. AGE: Years	Months	Days	If less than one day
78	4	12	hr. min.

9. Birthplace Md
(Town, county and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name James Sylvester Ridgely
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Ridgely
15. Birthplace Md.

16 (a) Informant Stanley J. Johns
(b) Address 806 Evesham Ave

17 (a) Burial (b) Date thereof 8/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Balto Md.

18 (a) Funeral director Wm. Cook Inc
Address 1317 St. Paul St

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Signature of registrar)
AUG 15 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1944, at 6:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6 1944 to 8/13 1944, and that I last saw h alive on 8/13 1944.

Immediate cause of death	Duration
Cerebral Thrombosis	hrs.
Due to Generalized Arteriosclerosis	
Due to Chronic CVD - compensated	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23, Signature Stanley J. Taylor M. D.
Address WBBM Date signed 8/13/44

Dr Kirby - 110 E North Ave.

G19894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19894

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 N. Calvert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 N. Calvert
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Bell Conner

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 17 1872

8. AGE: Years 71 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace VA.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER

12. Name E. Root

13. Birthplace VA.

14. Maiden Name Mary A. Hamilton

15. Birthplace VA.

16 (a) Informant Mrs Virginia Tietz

(b) Address 1637 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore

18 (a) Funeral director Wm Cook Inc.

Address 217 St Paul St.

19 AUG 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13- 1944, at 5 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Aug 13 1944, and that I last saw her alive on Aug 11 1944.

Immediate cause of death Cerebral apoplexy softening of brain

Due to Arteriosclerosis, Hypertension

Due to Chronic Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature H. J. Kirby

Address 110 E Northern Date signed 8/16/44 M.D.

G19895 ✓ G19895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

Y-51726

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Fill in correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4, 6, 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4400 Old York Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James M. Secrest

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Leslie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1884

8. AGE: Years	Months	Days	If less than one day
60	0	22	hr. min.

9. Birthplace Alabama (Town, county, and state)
10. Usual Occupation Newspaperman
11. Industry or business Unemployed

FATHER
12. Name William D. Secrest
13. Birthplace S. C.

MOTHER
14. Maiden Name Molly McLean
15. Birthplace Ala.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director Wm Cox Inc
Address 1317 St. Paul St

AUG 15 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14- 1944, at 10.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-9 1936 to 8/14 1944 and that I last saw h[illegible] alive on 8/14 1944

Immediate cause of death: Bronchopneumonia — Duration: 3 days
Due to
Due to
Other Conditions Arteriosclerotic Heart Disease, Hemiplegia — 7
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W K Smith
Address Balt. City Hosp Date signed 8/14/44 M. D.

G19896 BARRON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G19896

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 349 S. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Barrow

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Rose L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25. 869

8. AGE: Years 75 | Months | Days 7 17 | If less than one day hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name John Barrow
13. Birthplace Unknown

MOTHER
14. Maiden Name Frances - ?
15. Birthplace Wash. D.C.

16 (a) Informant Rose L. Barrow
(b) Address 349 S. Pulaski St,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 217 St. Paul St

19 (a) AUG 15 1944 (Date rec'd by registrar) (b) Huntingtown Prince Georges, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944 at 10 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-14 1944 to 8-12 1944 and that I last saw h.IM. alive on Aug 12 1944.

Immediate cause of death	Duration
Pneumonia	
Due to Bronchopneumonia	
Due to Arteriosclerotic C-V disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 8-12-44

G19897 32472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G19897 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 N. Madeira (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hewett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ella.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-25-95

8. AGE: Years 48 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Va. (Town, County, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Walter Hewett

13. Birthplace Va

MOTHER 14. Maiden Name Margaret White

15. Birthplace Va.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem. Location B.A. County Md

18 (a) Funeral director Thos. Robert A. Elliott, Jr.

(b) Address 1129 N. Carlton St

AUG 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944 at 7:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1944 to Aug 12 1944 and that I last saw him alive on Aug 12 1944

Immediate cause of death Perforated Peptic Ulcer with Subphrenic Abcess

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-9-44

Major findings of operation: Perforated Peptic Ulcer.

of autopsy: Subphrenic Abcess.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lucius R. Lindley, M.D.

Address Johns Hopkins Hosp. Date signed 8/12/44

G19898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1860 Registered No. G19898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 N. Port St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Sussan

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-14-0416

MEDICAL CERTIFICATION

20. DATE OF DEATH. August 13, 1944, at 8:30 P. M

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/1900

8. AGE: Years	Months	Days	If less than one day
43	10	27	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Helper National Brewery

11. Industry or business

FATHER
12. Name Adam Sussan
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Fritzges
15. Birthplace Baltimore, Md.

16 (a) Informant Catherine Leland
(b) Address 228 N. Port Street

17 (a) Burial (b) Date thereof Aug. 15 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Rd.

18 (a) Funeral director Henry G. Miller
(b) Address 2634 Jefferson St.

AUG 15 1944 (b)
(Date rec'd by Registrar) Registrar

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage
Laceration of Brain
Due to Fracture skull
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1943 at 12/27/43 M.
(b) Where did injury occur? S Caslin # 2308 Jeffer St. Bal. Md.
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? Yes
(d) Means of injury fell from truck while loading

23. Signature H. L. Wellenmeier M.D.
Medical Examiner.
Date signed August 17, 1944.

VS 151

C19899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

C19899 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Aisquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 Aisquith St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-07-7819

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Widowed

6 (b) Name of husband or wife Cealia
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1892

8. AGE: Years	Months	Days	If less than one day
51	7	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name ? Cornish
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Cornish
15. Birthplace Md

16 (a) Informant Etta Meeking
(b) Address 1208 Aisquith St.

17 (a) Burial (b) Date thereof 8/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Taylors Island, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1304 N. Central Ave

19 (a) (b) Huntington Williams, M.D.
Registrar

AUG. 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 21 1944, to Aug. 13 1944, and that I last saw h alive on Aug. 12 1944.

Immediate cause of death	Duration
Coronary Thrombosis	3
Due to Syphilis	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. K. Adams M. D.
Address 1222 N. Carlton Date signed Aug 14-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 727

✓ G19900 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1914 Herbert st
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LORIS MYERS

3 (b) If veteran, name war

3 (c) Social Security Account No. 178-05-7954

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret Mahoney Myers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 8. 1903

8. AGE: Years 41 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alpheus Myers
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Nellie A. Tate
15. Birthplace Maryland

16 (a) Informant Luydell Myers
(b) Address Hopewood Pa

17 (a) Removal (b) Date thereof Aug 15 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Uniontown Pa.

18 (a) Funeral director Harold S. Gleason
(b) Address Uniontown Pa

19 (a) (b)
(Date received by Registrar) Registrar
AUG 15 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 1944, at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/8 1944, to 8/14 1944, and that I last saw h/c alive on 8/14 1944.

Immediate cause of death Bleeding into brain stem

Due to aplastic anemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Martin M. D.

Address Univ. Hosp. Date signed 8/14/44

G19901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G19901
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grady Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife Louise Williams

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1917

8. AGE: Years	Months	Days	If less than one day
27 26	-	28	hr. min.

9. Birthplace Kings Mountain N C
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Eugene Williams
13. Birthplace N.C.

MOTHER
14. Maiden Name Bessie ?
15. Birthplace N C

16 (a) Informant Marie Holland (A)
(b) Address 104 Sharp St

17 (a) Removal (b) Date thereof 8/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Gastonia
Location N C

18 (a) Funeral director Donald F. Brown
(b) Address 109 W Montgomery St

19 AUG 15 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1944, at 1 25 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound
of neck

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 13 1944 1 A.M.
(b) Where did injury occur? 124 W Hamburg St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Stabbed

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed August 13 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

32 938802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G19902 $7D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1633 Miller St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie Fields

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 10-20-97

8. AGE: Years 46 | Months 9 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Robinson
13. Birthplace (Md)

MOTHER
14. Maiden Name Henrietta Bryant
15. Birthplace (Md)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 1303 Presstman St

19 (a) (Date rec'd by registrar) (b) Registrar

VS AUG 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-1944, at 1 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13-1944, to 8-14-1944, and that I last saw h[illegible] alive on 8-14-1944.

Immediate cause of death Myocarditis
for Tri Coronement
Due to ? anesthesia
Due to
Other Conditions None
(Include pregnancy within 3 months of death)

Duration

Date of operation 8-14-44
Major findings of operation: Negative
of autopsy: Negative

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature
Address Hugh A. Riggle Date signed 8-15-44

G19903

BALTIMORE CITY HEALTH DEPARTMENT ✓ G19903

CERTIFICATE OF DEATH 183 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) Do a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 48 Market Place (If outside city or town limits, write RURAL and give town)
Street No. Balto. Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Thomas Steadman

3 (b) If veteran, name war Korea War #2
3 (c) Social Security Account No. 578-03-8761

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1902

8. AGE: Years 42 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Va. (Town, county and state)
10. Usual Occupation Sign Painter
11. Industry or business

FATHER
12. Name Clarence E. Steadman
13. Birthplace ?

MOTHER
14. Maiden Name Ida K. Nichols
15. Birthplace Md.

16 (a) Informant George Walling
(b) Address Washington, D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-15-44 (month) (day) (year)
(c) Cemetery or crematory Arlington Natl.
Location St Mayn Va

18 (a) Funeral director Wilson Funeral Home Inc
(b) Address 1214 E Capitol St

19 (a) AUG 15 1944 (Date rec'd by Registrar) (b)

Huntington Hollins Funeral Home

MEDICAL CERTIFICATION

20. DATE OF DEATH August 3, 1944 at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found August 2 3/2 1944 2 P.M.
(b) Where did injury occur? Rock of Presidents Head
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Found drowned

23. Signature Robert Lee Graham M.D. (Medical Examiner.)
Date signed August 7 1944

VS 151

G19904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G19904 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6213 Pinehurst Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6213 Pinehurst Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. Crosson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Mary B. Crosson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1867

8. AGE: Years	Months	Days	If less than one day
77	4	19	hr. min.

9. Birthplace Phila. Pa
(Town, country, and state)
10. Usual Occupation Hosiery Manufacturer
11. Industry or business Retired

FATHER
12. Name Crosson
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant Mr. Crosson
(b) Address 6213 Pinehurst Road

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug. 16/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 114 Greenmount Ave

19 (a) (Date received by registrar) AUG 15 1944 (b) Huntington Wiedefeld Weber

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14th 1944, at 1.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death Coronary Occlusion — Duration Sudden

Due to

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. K. Eudy M. D.
Address 7201 York Rd Date signed 8-14-44

Approved: per Robert Lee Dickson M.D.

G19905

BALTIMORE CITY HEALTH DEPARTMENT

TN. 89341 CERTIFICATE OF DEATH 48a

Registered No. G19905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 326 Whitridge St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Treva O'Mara (Treva Viola O'Mara)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215 - 01 - 9789

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Joseph T. O'Mara

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 25, 1902

8. AGE: Years 42 | Months 3 | Days 18 | If less than one day hr. min.

9. Birthplace Maryland (Millers, Carroll Co.)
(Town, county, and state)

10. Usual Occupation -- May Co.

11. Industry or business

FATHER
12. Name Jos. M. Frank
13. Birthplace Maryland (Balto. Co.)

MOTHER
14. Maiden Name Minerva E. Zumbrun
15. Birthplace Maryland (Carroll Co.)

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof 8/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 AUG 15 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15, 1944 19 , 2 P.M. at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 1944 to 8-13 1944, and that I last saw h.CK alive on 8-13 1944.

Immediate cause of death: Cachexia — Duration: Unknown

Due to: Far advanced carcinoma of the cervix

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Houck E. Balton M.D.
Address Balt. City Hosp. Date signed 8/17/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19906 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5324 Wesley Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5324 Wesley Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lewis B Weems

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Emma Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1856

8. AGE: Years	Months	Days	If less than one day
88	4	13	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired Builder
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mr. Owens D. Weems
(b) Address 2355 W. North Ave. 17

17 (a) Burial (b) Date thereof 8/16/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 15 1944 (b) Hunterton Williams M.D.
(Date received by Registrar) Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1944, at 9 P M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy find that said deceased came to ~~his~~ death on the day stated above.

Immediate cause of death Arteriosclerotic Cardio-Vascular disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed August 14 1944

G19907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G19907 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4412 Wrenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Roanoke (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA SUSAN McNAMEE

3 (b) If veteran, name war --
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Jesse D. McNamee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 25, 1861

8. AGE: Years 82 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace Salem, Va. (Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name William Duiguid
13. Birthplace Va.

MOTHER
14. Maiden Name Harriet Duiguid
15. Birthplace Va.

16 (a) Informant Mrs. Elizabeth D. Aker
(b) Address 4412 Wrenwood Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/15/44 (month) (day) (year)
(c) Cemetery or crematory
Location Roanoke, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 15 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1944, at 4:40A M

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Aug. 12, 1944~~ 8/14 1944, and that I last saw her alive on 8/14 1944

Immediate cause of death: Acute Pulmonary Edema — Duration: 5 hours
Due to: Arteriosclerotic Cardio vascular disease — 2 years
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Anthony J. Thomas M. D.
Address 4609 York Road Date signed 8/15/44

Approved: Robert Lee Chatham M.D. 8/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

WOTTEN 97

G19908 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1404 Dotten
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 2
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1404 Dotten (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thos. Walter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widower

6 (b) Name of husband or wife Mary Wotten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1868

8. AGE: Years	Months	Days	If less than one day
75	8	24	hr. min.

9. Birthplace Md (city or county and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Mary Rhoda
15. Birthplace Md

16 (a) Informant Mrs. E. Walter
(b) Address 1404 Dotten

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Hill Cemetery
Location Annapolis R. R. Co., Md

18 (a) Funeral director Mrs. E. H. B. Baker
(b) Address 417 W. Baltimore St. Annapolis, Md.

19 (a) AUG 15 1944 (b) Registrar

78 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/1944 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1/1943 to 8/14/1944, and that I last saw h[illegible] alive on 8/14/1944.

Immediate cause of [illegible] Chronic Nephritis 2 yrs
Due to Senile Gangrene
Due to Arteriosclerosis

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature H. Eu Sles M. D.
Address [illegible] Date signed 8/14/44

G19909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

× ✓ G19909

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Frederick
(c) City or town Frederick
(If outside city or town limits, write RURAL and give town)
(d) Street No. R F D #1
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Edward Hamilton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elsie

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-22-78

8. AGE: Years 65 66 | Months 10 | Days 22 | If less than one day ..... hr. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business

FATHER 12. Name George Hamilton
13. Birthplace Md.

MOTHER 14. Maiden Name Margaret Kellert
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 18 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Union Chapel near Fifty Town Md.
Location

18 (a) Funeral director Burdette Albaugh
(b) Address Woodsboro Md.

AUG 15 1944 (b) Huntington Williams M.D.
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944 at 5:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944 to Aug 14 1944 and that I last saw h[illegible] alive on Aug 14 1944

Immediate cause of death: Peritonitis & Peritoneal Abscesses — Duration: 14 days

Due to: Ruptured Diverticulum

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Aug 4, 1944

Major findings of operation: Peritonitis & Ruptu Peritoneal Abscesses

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?
(Specify type of place)
(e) Means of injury.....

23. Signature George Burnell M. D.
Address J. H. H. Date signed 8-15-44

G19910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G19910
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(a) Street address 4728 Frederick Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4728 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry W. Smallwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Helen M. O'Leary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1895

8. AGE: Years 49 | Months 1 | Days 7 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Mgr
11. Industry or business A. & P. Co.

FATHER
12. Name Dallas Smallwood
13. Birthplace Md

MOTHER
14. Maiden Name Jennie Croney
15. Birthplace Md.

16 (a) Informant Helen M. Smallwood
(b) Address 4728 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 44 (month) (day) (year)
(c) Cemetery or crematory National
Location Frederick Rd

18 (a) Funeral director Harry H. Keith
(b) Address 410 E. Monument Ave

19 AUG 15 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 44 19 , at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 10 1944 to Aug 12 1944, and that I last saw h alive on Aug 12 1944

Immediate cause of death Cerebral Hemorrhage — Duration 6 wks

Due to Cerebral Arterio Sclerosis — 8 mos

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature James H. Howell M.D.
Address 715 Fred Av Date signed 8-16

James H. Howell

G19911

HAIR

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G19911

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 N. Castle St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 122 N. Castle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillis Irene Hair

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1942

8. AGE: Years 1 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Orangeburg, S. C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER: 12. Name Willie Hair
13. Birthplace S. C. ?

MOTHER: 14. Maiden Name Marion
15. Birthplace S. C.

16 (a) Informant Geneva Black
(b) Address 122 N. Castle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)

(c) Cemetery or crematory
Location Orangeburg, S. C.

18 (a) Funeral director Elroy S. Wilson
(b) Address 1000 Bruntley Ave

AUG 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13 1944 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1944 to Aug 13 1944.
and that I last saw h[illegible] alive on Aug 12 1944.

Immediate cause of death

Duration

Due to Acute Bronchopneumonia — Aug 12 1944

Due to Cold

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation no

Major findings of operation:

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed [illegible]

Spratley

G19912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G19912

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1103 Chamberlain St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Chamberlain Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John E. Spratley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charlotte Spratley
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1883

8. AGE: Years 61 | Months 5 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edmund Spratley
13. Birthplace Va.

MOTHER
14. Maiden Name Eva James
15. Birthplace Va.

16 (a) Informant Mrs. Charlotte Spratley,
(b) Address 1103 Chamberlain St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17-44 (month) (day) (year)
(c) Cemetery or crematory Arlington Mem. Pk.
Location Baltimore, Co.

18 (a) Funeral director Rogers Funeral Dir.
(b) Address 1412 E. Preston St. Baltimore, Md.

19 (a) Filed AUG 15 1944 (b) [illegible] Registrar
File No.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14 19.... at 11 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 1944 to 8/14 1944 and that I last saw him alive on 8/13/44 19....

Immediate cause of death	Duration
Due to Cerebral	
Due to Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address 1103 Chamberlain Date signed 8/14/44

1151

G19913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92a

Registered No. G19913

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Amherst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2762 Tivoly Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul H. Wolf

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
no.	212-09-1171	M	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14. 1896

8. AGE: Years 48 | Months | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Blue Print Cutter
11. Industry or business Copper Co.

FATHER
12. Name Philip Wolf.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Diesel
15. Birthplace Baltimore

16 (a) Informant Miss Etta Wolf
(b) Address 2762 Tivoli Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or crematory Emmanuel
Location Druid Hill Ave & Lanvale St

18 (a) Funeral director J. Bernard Lee
(b) Address 1544 W. Baltimore St.

19 AUG 15 1944 Hunting for Mortuary
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13. 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 30, 1943 to Aug. 13 1944, and that I last saw him alive on Aug. 12, 1944.

Immediate cause of death	Duration
Acute dilatation of heart	3 hrs.
Due to Mitral stenosis. Aortic regurgitation. Chronic	1 yr.
Due to Myocarditis.	

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred E. Fitzgerald M. D.
Address 1613 E. North Ave. Date signed 8-14-

G19914
Dr Boyle
52 Hartford Rd.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH §3a

G19914
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 2501 Louise Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Louise Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ward

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Bridget T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1863

8. AGE: Years	Months	Days	If less than one day
80	7	14	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Francis Ward
13. Birthplace Ireland

MOTHER
14. Maiden Name Julia McDermot
15. Birthplace Ireland

16 (a) Informant Mrs Margaret H. Cole
(b) Address 254 Louise Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location

18 (a) Funeral director L. J. Rusk
(b) Address 5305 Harford Rd

AUG 15 1944 (Huntington Williams, M.D.)
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944 at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 8 1944 to Aug 12 1944, and that I last saw him alive on Aug 11 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arterio Sclerosis	
Due to Hypertension & Senility	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Brooke Boyle M. D.
Address 521 N. Hartford Rd Date signed 8/12/44

G19915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56B

✓ G19915

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Fayette & Calhoun
(b) Street address 835 N. Bentalou
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 835 Bentalou st
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Rose Fertitta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 24 - 1890

8. AGE: Years	Months	Days	If less than one day
53	8	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Hugh Fitzpatrick
13. Birthplace Pa

MOTHER
14. Maiden Name Mary Mullen
15. Birthplace Ohio

16 (a) Informant Husband Rosario Fertitta
(b) Address 835 N. Bentalou st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Lipitone
(b) Address 251 E. Balto st

19 (a) (Date received by Registrar) AUG 17 1944 (b) Huntington Park Baltimore, Md. (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 13, 1944, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 1944, to 8-13 1944 and that I last saw h.. alive on 8-13 1944.

Immediate cause of death	Duration
Heat exhaustion	1 Day
Due to	
Due to	
Other Conditions Hysterectomy + Appendectomy (Include pregnancy within 3 months of death)	7-15-44
Major findings: Of operations Myoma	
Of autopsy	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. D. Engel M. D.
Address Medical Arts Bldg Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

19916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G19916

Registered No. 1147

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y.N.Y. (b) County
(c) City or town New York City (If outside city or town limits, write RURAL and give town)
(d) Street No. 80 Bleecker St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Trinidad

3 (a) FULL NAME (RAMON) Raymond Luigi
3 (b) If veteran, name war W
3 (c) Social Security Account No. none
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7-7-99
8. AGE: Years 45 | Months 1 | Days 3 | If less than one day hr. min.
9. Birthplace Trinidad (Town, county, and state)
10. Usual Occupation Foreign Commercial
11. Industry or business Timber

FATHER
12. Name Raymond Luigi
13. Birthplace (Corsica)

MOTHER
14. Maiden Name Josephine Cardier
15. Birthplace Venezuela

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (b) Date thereof 8/21/44 (burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CARACAS
Location CARACAS, VENEZUELA
18 (a) Funeral director Milford Co Inc
(b) Address 1217 E Fort St
AUG 15 1944 (Date rec'd by registrar) (b) Huntington Williams, W.Va.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-10- 1944, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-14 1944, to 8-10 1944 and that I last saw him alive on 8-10 1944.

Immediate cause of death Pulmonary hemorrhage; left, post-pleurisy — Duration
Due to Chronic lung abscess, left
Due to Salmonella aerotype
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 7-4-44
Major findings of operation: Lung abscess, left
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ross L. McLean, M. D.
Address Johns Hopkins Hosp. Date signed 8-11-44

G19917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G19917
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3136 Oakford Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3136 Oakford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred F. Hirman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas Hirman
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) December 15, 1901

8. AGE: Years	Months	Days	If less than one day
42	7	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Robert Hammond
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Clara May Griffith
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Thomas Hirman
(b) Address 3136 Oakford Ave.

17 (a) Burial (b) Date thereof Aug. 16, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director Willis Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) (Date received by Registrar) AUG 15 1944 (Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 1944, at 8.10P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to Aug 12 1944 and that I last saw her alive on Aug 10 1944

Immediate cause of death: Coronary Clot — Duration: Some?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 3321 Frederick Ave Date signed 8-14-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G19918 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 N Eutaw St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2219 N. Pulaski St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret S. Trumblefield

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alfred S. Trumblefield

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1880

8. AGE: Years	Months	Days	If less than one day
63 64	8	1	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Home Duties

11. Industry or business

FATHER
12. Name William Nolan
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth V. Sewell
15. Birthplace Baltimore

16 (a) Informant Alfred S. Trumblefield
(b) Address 2219 N. Pulaski St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 15 1944 (month) (day) (year)
(c) Cemetery or crematory Westlawn
Location Baltimore

18 (a) Funeral director Frederick A. Pelle
(b) Address 2000 Lombard St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944 at 9:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1944, to Aug. 11 1944, and that I last saw her alive on Aug. 11 1944.

Immediate cause of death	Duration
Coronary thrombosis	7
Due to Adv. Atherosclerosis	
Due to	
Other Conditions Auc. Fibrillation Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Jacob M. D.
Address 1700 Eutaw St. Date signed Aug. 14-1944

G19919 G19919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Palaski St
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3054 Stafford St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Burke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edwina Burke

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Sept 24th 188[illegible]

8. AGE: Years 64 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation Lay Out Nurse

11. Industry or business Bartlett-Hayward

FATHER
12. Name Silas E Burke
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary J. Mc Olde
15. Birthplace Maryland

16 (a) Informant Edward Burke
(b) Address 3054 Stafford St.

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] Aug 17/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director J. A. Hilgert Son
(b) Address Baltimore Maryland

19 (a) (b)
(Date received) (Registrar) Registrar

AUG 15 1944

VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1944 at 4.02 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1944 to 8-15- 1944 and that I last saw h[illegible] alive on 8-14 1944

Immediate cause of death: Hypostatic Pn. — Duration

Due to: Ca Lip mid

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 8-19-44

Major findings of operation: Ca Sigmoid

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. Vogel, Jr. M. D.
Address Bon Secours Hosp. Date signed 8-15-44

G19920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G19920 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3049 Frederick Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emory J. Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17th 1894

8. AGE: Years 45 | Months — | Days 27 | If less than one day — hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation House Painter

11. Industry or business

FATHER
12. Name Geo. E. Smith
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Munk
15. Birthplace Maryland

16 (a) Informant Camilla L. Smith
(b) Address 1316 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/44 (month) (day) (year)
(c) Cemetery or crematory Mount Clair
Location Baltimore, Md

18 (a) Funeral director J. S. Waltjen & Son
(b) Address 1811 Pennsylvania Ave

19 (a) AUG 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1944, at 5:40 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-13-44 Balto. Co. M.
(b) Where did injury occur? Pt. Pleasant Rd
(c) Did injury occur at home, on farm, industrial place, in public place? Auto - While at work? —
(d) Means of injury auto struck culvert

23. Signature J. J. Wallenweber M.D. Medical Examiner.
Date signed August 16 1944

G19921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G19921

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 638 N. Barre St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pvt. Hayes H. Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1922

8. AGE: Years	Months	Days	If less than one day
22			hr. min.

9. Birthplace Danville, Va. (Town, county, and state)

10. Usual Occupation Soldier

11. Industry or business U. S. Army

FATHER
12. Name M. C. Allen
13. Birthplace Va.

MOTHER
14. Maiden Name Talamina Cunningham
15. Birthplace Va.

16 (a) Informant Rev. M. C. Allen
(b) Address 638 N. Barre St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-44 (month) (day) (year)
(c) Cemetery or crematory U. S. National
Location Balto., Md.

18 (a) Funeral director Collins & Jackson
(b) Address 916 Pennsylvania Ave.

19 (a) (Date received by registrar) By Registrar
Huntington Hollowell, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1944, at 4:25 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning, accidental.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-13-44 at 3:30 P. 25/6 M.
(b) Where did injury occur? Severn Canal + Gravel Co. Maryland
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Drowned while swimming at above place.

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed August 17, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

327997
G19922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19922

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2238 Sidney Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha KINNAMONT
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
(b) Name of husband or wife: Edward E Kinnamont
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 10-5-88

8. AGE: Years 55 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Aaron ?
13. Birthplace Ger.

MOTHER
14. Maiden Name Mollie Herman
15. Birthplace Ger.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-16-44 (month) (day) (year)
(c) Cemetery or crematory McDonogh Cem.
Location

18 (a) Funeral director Loring Byrne
(b) Address 6005 Pk Heights Ave

19 (a) (Date received by registrar) (b) Huntington Mills Registrar, M.D.

AUG 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 12 1944 at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28- 1944, to 8-12 1944, and that I last saw her alive on 8-12- 1944

Immediate cause of death: Central hemorrhage — Duration 2 wks.

Due to ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 7-29-44

Major findings of operations: Cerebral hemorrhage

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Meyer A. Rapoport M. D.
Address Johns Hopkins Hosp. Date signed 8-13-44

G19923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ G19923 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Brune Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Brune Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William E Garlington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Beulah

6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) , 1897

8. AGE: Years 46 | Months | Days | If less than one day hr. min.

9. Birthplace Atkins, Ark.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Sidney Garlington

13. Birthplace ?

MOTHER 14. Maiden Name Lucy Downs

15. Birthplace Charleston, N.C.

16 (a) Informant Beulah Garlington

(b) Address 703 Brune St

17 (a) Burial (b) Date thereof 8/16/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location A. A. Co. Md.

18 (a) Funeral director Chas H Algire Sr.

(b) Address 927 N. Mount St

19 (a) (b)
(Date received in registrar's office) (Registrar)

VS 151 AUG 15 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1944, at 12 45 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Hes death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilis cerebro due
gangrene of leg

Due to Arteriosclerotic Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Le Gautier M.D.
Medical Examiner.

Date signed Aug 15 1944

320 #19924 Pelke ✓ G19924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2334 E. Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Pelke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or ~~wife~~ Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-17-77 ?

8. AGE: Years	Months	Days	If less than one day
66	8	27	hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Heinrich Bolte
13. Birthplace (Ger.)

MOTHER
14. Maiden Name Betty Bake
15. Birthplace (Ger.)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 8/17/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or ~~Crematory~~ Moreland Memorial
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) AUG 15 1944 2601 E. Madison Street

19 (a) (b)
(Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14- 1944 at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1944 to 8-14- 1944 and that I last saw her alive on 8-14- 1944

Immediate cause of death: Intracranial hemorrhage Carcinoma of Esophagus — Duration: Acute / Chronic

Due to: Arteriosclerotic Cardiovascular disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Arthur T. Ward, M.D.

Address Johns Hopkins Hospital Date signed 8/15/44

G19925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G19925 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 610 N. Luzerne Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 610 N. Luzerne Avenue
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline Tarr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Norman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/2/06

8. AGE: Years 37 yrs. | Months 8 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Chevrolet

FATHER
12. Name Konrad Sponsal
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Eyrick
15. Birthplace Germany

16 (a) Informant Parents
(b) Address 610 N. Lazerne Aveme

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or Crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) 5 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1944 at 8P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 3 1944 to 8/13 1944 and that I last saw [illegible] alive on 8/12 44

Immediate cause of death: Carcinoma of Cervix — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Jan 4, 1944

Major findings of operation: Metastatic Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas B Ware M.D.

Address 601 N Luzerne Date signed 8/14/44

VS 250

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dorsey ✓ G19926

G19926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 E 38th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 E 38th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

9-1

3 (a) FULL NAME Emma Jane Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband/wife Wm H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1867

8. AGE: Years 77 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Parker Lenhart
13. Birthplace Lancaster Co Pa

MOTHER
14. Maiden Name Margaret Hooper
15. Birthplace Pennsylvania

16 (a) Informant Jess E Griffith
(b) Address 601 E 38th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director J. Wm. A. Jackson
(b) Address 4501 Harewood Ave

19 (a) (Date received by registrar) (b) Filing Number Washington Millimore M.D.

AUG 15 1944

VS 3

Approved: Robert Lee Graham M.D. 8/15/44

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944, at 12:45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/14 1944 to Aug 7 1944 and that I last saw h[illegible] alive on Aug 7 1944.

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Arteriosclerotic CVHD, Gen. Arteriosclerosis	
Due to Chr. Arthritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Loreland Applegarth

Address 2511 Reisterstown Date signed 8/15/44

G19927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19927 Registered No. 937

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 Wyanoke Av.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 Wyanoke Av. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME John Francis Ellis.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Mrs. Carrie W. Ellis
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 14, 1875

8. AGE: Years	Months	Days	If less than one day
69	3	—	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired meter maker
11. Industry or business Md. Meter Works

FATHER
12. Name William Ellis
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Schultz
15. Birthplace Baltimore

16 (a) Informant Mrs. Carrie Ellis
(b) Address 628 Wyanoke Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date there Aug 17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Frederick Road

18 (a) Funeral director John G. Mosan
(b) Address 3000 E. Baltimore St.

19 (Date filed by registrar) Aug 15 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1944 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1944 to Aug 14 1944 and that I last saw h alive on Aug 13 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	6/14/44
Due to Chr. Myocarditis	1935
Due to Arterio Sclerosis	1935
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Brown
Address 1630 W. North Av. Date signed 8/14/44 D.

G19928 G19928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48C

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Windermere Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Windermere Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Mc-Donough

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leo F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1901

8. AGE: Years	Months	Days	If less than one day
43	6	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Peter Letwin
13. Birthplace Lith

MOTHER 14. Maiden Name Martha Panza
15. Birthplace Italy

16 (a) Informant Leo F McDonough
(b) Address 1314 Windermere Rd

17 (a) Burial (b) Date thereof Aug 17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Road

18 (a) Funeral director John C Mosan
(b) Address 3000 E Baltimore St

19 (a) AUG 15 1944 (b) Huntingtn Williams, M.D.
(Date received by registrar)

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1941, to Aug 14 1944, and that I last saw h or alive on Aug 13 1944

Immediate cause of death	Duration
Cardiac dilatation +	
Arteriosclerosis	2 days
Due to Exhaustion	
Due to Gen Carcinomatosis	
following carcinoma uteri	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E K Haywood (M.D.)

Address 115 E Eager Date signed 8/15 1944 M. D.

G19929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19929

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 W. 40th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriet E. Columbus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow.

6 (b) Name of husband or wife Amtides Columbus

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1863

8. AGE: Years	Months	Days	If less than one day
80 81	11	12	...hr. ...min.

9. Birthplace Maryland.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown.
15. Birthplace Unknown.

16 (a) Informant Elaine Lowery
(b) Address 1102 W 40th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Bladensburg Md.

18 (a) Funeral director Edmonds & Penovar
(b) Address 915-17 Eastern Ave.

19 (a) AUG 16 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1944, at 7 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed August 14, 1944

G19930 T.G.P.--16106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G19930 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Charles Shauck
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 yrs. 9 mos. 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 777 W. Lexington Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Shauck--or Schanck

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, year) Dec 1, 1883 ?

8. AGE: Years	Months	Days	If less than one day
60 ~~yrs~~	8	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Shauck
13. Birthplace Maryland

MOTHER
14. Maiden Name Sadie ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) [illegible] Lexington Mt. Olivet

AUG 16 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1944 19 , at 11:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1929, to 8/12 1944 and that I last saw h[illegible] alive on 8/12 19 44

Immediate cause of death Coronary Thrombosis — Duration Sudden

Due to Arteriosclerotic Heart Disease

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. K. Swick M. D.
Address Balt. City Hosp Date signed 8/12/44

G19931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G19931 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 S. Smallwood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Helen Hauf

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband ~~or wife~~ George A.
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 1870

8. AGE: Years	Months	Days	If less than one day
74	3		hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Bowen
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Butler
15. Birthplace Pa.

16 (a) Informant Mr. George Hauf
(b) Address 15 S. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Fred. A. Krause & Son
(b) Address 1216 N. Charles St.
(c) Huntington Williams Mgr (Registrar)

AUG 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/13 1944, at 8:20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/3 1944 to 8/13 1944, and that I last saw h[illegible] alive on 8/13 1944

Immediate cause of death

Due to Cardiac Failure

Due to Diabetes Mellitus
Osteomyelitis
Kraurosis Penum

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence May 7 1944 at M
(c) Where did injury occur? Baltimore Md
15 S. Smallwood St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? No.
(Specify type of place)
(e) Means of injury Fell from chair.

23. Signature A. A. Guyton M. D.
Address Date signed

Approved: Robert L. Bratton M.D. Hosp. 8/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19932 Schmidt ✓ G19932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline St.
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4629 Asbury Ave (If rural give location)
(e) Citizen of foreign country? Austria (Yes or No)
If yes, name country

3 (a) FULL NAME Christian F. Schmidt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Barbara Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 18 1865

8. AGE: Years 79 | Months 6 | Days 28 27 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Business Man

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace Germany

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Arnd Deubleman
(b) Address 4407 Furley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Howard V. Blight Jr.
(b) Address 4914 Belair Road

AUG 16 1944 (Date filed) for William H. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1944 at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14/44 19 , to 8/15 1944, and that I last saw h alive on 8/15 1944.

Immediate cause of death Pulmonary Oedema — Duration

Due to Cardiac Decomp.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address St Joseph Hosp Date signed 8/16/44

G19933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 931

Registered No. G19933

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4911 Roland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 47 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4911 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? ------ (Yes or No)
If yes, name country ------

3 (a) FULL NAME Valerie Vogeler Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles J. Brooks
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1896

8. AGE: Years	Months	Days	If less than one day
47	10	14	-- hr. --- min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation --------
11. Industry or business --------

FATHER
12. Name Edward J. Vogeler
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Laura Grah
15. Birthplace Baltimore, Maryland

16 (a) Informant Charles J. Brooks
(b) Address 4911 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) AUG 16 1944 (Date received by Registrar) (b) Huntington Millcreek, Md. • Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1944, at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1935 to Aug 15 1944, and that I last saw her alive on 8/14/1944.

Immediate cause of death Myocarditis — Duration Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature M. H. Grady
Address 140 S. Park Ave. Date signed 8/15/44

G19934 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

G19934 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/15/44
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Luzerne Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT EDWARD MARTIN

3 (b) If veteran, name war - ND
3 (c) Social Security Account No. NONE

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/16/1862

8. AGE: Years 82 | Months 5 | Days 30 | If less than one day 19 hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation Master

11. Industry or business Merchant Marine

FATHER
12. Name William Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Ireland

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Fulton & Company
(b) Address 1214 Park Ave

19 AUG 16 1944 (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Aug. 15, 1944, at 2:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1944, to Aug. 15, 1944, and that I last saw him alive on Aug. 15, 1944

Immediate cause of death Hemorrhagic diathesis due to unknown cause with massive hemorrhages into ~~xxxx~~ left thorax, retroperitoneal tissues and right leg. — Duration: Unk.

Due to

Other Conditions Secondary infection of hematomata of right leg.
(Include pregnancy within 3 months of death)

Date of operation 8/9/44-Aspiration of rt. ankle

Major findings of operation: Abscess of subcut. tissues of rt. ankle

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Altemus
Address Baltimore, Md. Date signed 8/15/44

MS-54186

G19935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G19935

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2602 Southern Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 27

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2602 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter F. Miller

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-03-4166

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Anna D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1877

8. AGE: Years 66 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Compositor
11. Industry or business Balto. News Post

FATHER
12. Name Charles F. Miller
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Anna Remley
15. Birthplace Baltimore, Md.

16 (a) Informant Anna D. Miller
(b) Address 2602 Southern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md

18 (a) Funeral director Wilson Co Inc
(b) Address 1217 E Fayette St

19 (a) AUG 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1944, at 7A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed August 15, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19936
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 Madison Ave.
(c) Hospital or institution:
Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 N. Green Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wayne H. Seachrist
3 (b) If veteran, name war: None
3 (c) Social Security Account No. 226-10-6749

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Florence D. Branaby
6 (c) If alive, give age 44 years
7. Birth date of deceased (mo., day, yr.) July 23, 1894
8. AGE: Years 50 | Months 0 | Days 22 | If less than one day ######## min.
9. Birthplace Coatesville, Pennsylvania (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Sparrows Point Ship yard

FATHER
12. Name John Henry Seachrist
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Emma Harlan
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Florence D. Branaby
(b) Address 1 N. Green Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave., Balto. Co.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1755 Harford Avenue

19 (a) (Filed by registrar) (b) Registrar
AUG 16 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 44, at 930 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9 19 44 to 8-15 19 44, and that I last saw him alive on 8-15 19 44

Immediate cause of death Hemorrhage
Cachexia

Duration: 8 mos.

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. H. Traynor M. D.
Address Wed. Cecil Hosp., Date signed

G19937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No. G19937

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 Park Heights Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

15-12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Parkheights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Jacobson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61 60			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Bernard Lewis
13. Birthplace Russia

MOTHER
14. Maiden Name Anna Freiman
15. Birthplace Russia

16 (a) Informant Henry Jacobson
(b) Address 3700 ParkHeights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date received) (b) Registrar

AUG 16 1944 Huntington Ave, Md.

Vs 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan, 1931, to Aug. 15 1944, and that I last saw h alive on Aug, 15 1944.

Immediate cause of death Cerebral Hemmorrhage
Due to Hypertension & nephritis
Due to Hypertension
Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: —

of autopsy: —

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Schapiro M. D.
Address 2028 Eutaw Place Date signed 8/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

618938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 ✓ Registered 618938

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1013 N. Central Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10/1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 N. Central Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME John Henry Stokes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3, 1906

8. AGE: Years 38 | Months 5 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bldg. Dry Dock

FATHER
12. Name Harry Stokes
13. Birthplace Va.

MOTHER
14. Maiden Name Rosie Fountain
15. Birthplace Va.

16 (a) Informant Robert Stokes
(b) Address 1013 Central Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location a. a. County Md.

18 (a) Funeral director Mrs. Robert Elliott Sykes
(b) Address 129 N. Carlton St.

AUG 16 1944 (by Huntington Williams M.D.)
Date rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-1944 12:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1944 to 8-14 1944 and that I last saw him alive on 8-14 1944

Immediate cause of death: Lobar Pneumonia & Pericarditis — Duration 2 Days

Due to: Infection

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas R. Blake M. D.

Address 137 N. Central Ave Date signed 8/15/44

G19939

AB-89254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

G19939 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1919 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Anthony P. Clifford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23-1935

8. AGE: Years 8 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Anthony Clifford
13. Birthplace Maryland

MOTHER
14. Maiden Name Beatrice Cockey
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Robert A. Elliott & Dy
(b) Address 1129 N. Caroline St.

AUG 16 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14- 1944, at 8.25A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-2- 1944 to 8-14- 1944, and that I last saw him alive on 8-14- 1944.

Immediate cause of death: Tbc. meningitis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Tbc. meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W. Holfrich M. D.
Address Baltimore City Hospitals Date signed 8-15-44

G19940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944N

G19940 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE SAPPERSTEIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife PAUL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name HARRY FRIEDMAN
13. Birthplace RUSSIA

MOTHER 14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant MRS. ROSE FRIEDLER
(b) Address 1701 W. FAYETTE ST

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-16-44 (month) (day) (year)
(c) Cemetery or crematory Pikesdale
Location

18 (a) Funeral director JACK LEWIS INC
(b) Address 1139 E. BALTO. ST

19 AUG 16 1944 (Date rec'd by registrar) (Signature) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1944 at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to 8/15 1944 and that I last saw h alive on 8/15 1944

Immediate cause of death: Coronary artery disease — Duration: 4 yrs

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.

Address 2404 Pennsylvania Ave Date signed 8/16/44

G19941

BALTIMORE CITY HEALTH DEPARTMENT ✓ 131a G19941

CERTIFICATE OF DEATH

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 N. Calvert
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35Yrs

12 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 N. Calvert ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip M. Griffith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21/ 1872

8. AGE: Years 72 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John M. Griffith
13. Birthplace Maryland

MOTHER
14. Maiden Name Rachel A. Norris
15. Birthplace Maryland

16 (a) Informant Mrs Arie Mathheys
(b) Address 1803 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet
Location Fredrick Ave.

18 (a) Funeral director John O. Mitchell
(b) Address 1900 Eutaw Place

AUG 16 1944 (b) Huntington Williams M.D.
(Date received by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 19 44, at 11A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/15/44 19 , to 9/15 1944, and that I last saw h[illegible] alive on 8/15 1944.

Immediate cause of death. Uremia — Duration

Due to Congestive Heart failure

Due to Arteriosclerotic CV&D

Due to Generalized Arteriosclerosis Chronic Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard J. Masters M.D.

Address 2511 Reisterstown RD Date signed 8/15/44

For S. H. Woolman by Howard J. Masters, M.D.

329066 G19942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30d

G19942 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 W Biddle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Johnson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-23-96

8. AGE: Years	Months	Days	If less than one day
48	-	21	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Edward Johnson
13. Birthplace S.C.

MOTHER
14. Maiden Name Annie ?
15. Birthplace S C

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. H. Kelly
(b) Address 1303 Freemason St

19 (a) (Date received by registrar) (b) Registrar

AUG 16 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944 at 1 58 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1944 to 8-14- 1944 and that I last saw h[illegible] alive on 8-14- 1944

Immediate cause of death — Duration

Gastro-intestinal hemorrhage — 1 week

Due to ? aneurysm / aorta

Due to ? Bleeding ulcer

Other Conditions Syphilitic arteritis ? aortic insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible]
Address Hopkins H. Date signed 8-16-1944 M. D.

G19943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56 X ✓ G19943 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns Hopkins
(c) Hospital or institution:
Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Elizabeth Hill
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-0549

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1897

8. AGE: Years	Months	Days	If less than one day
46	11	15	3 hr. 17 min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation office manager
11. Industry or business

FATHER
12. Name Haden F. Hill
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida May Jones
15. Birthplace Maryland

16 (a) Informant Hosp. Record
(b) Address

17 (a) Burial (b) Date thereof Aug 17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Gilead
Location Woodensburg, Baltimore
18 (a) Funeral director Edwood A Tipton
(b) Address Hampstead Md.
19 (a) (Date rec'd by registrar) (b) Huntington Nalbandian, Registrar
AUG 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16/44 19 0120 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/6/44 19 to 8/16/44 19, and that I last saw her alive on 8/15/44 19.

Immediate cause of death	Duration
Respiratory failure	
Due to peritonitis	
Due to ulceration	
Other Conditions Myoma uterus (Include pregnancy within 3 months of death)	

Date of operation 8/9/44
Major findings of operation: Myoma Uterus
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Felix Rutledge M.D.
Address Womens Hosp. Date signed 8/17/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G19944 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1236 E. Madison St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Georgianna James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Joshua

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3, 1889

8. AGE: Years 55 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Reed
13. Birthplace Va.

MOTHER 14. Maiden Name Maaha ?
15. Birthplace Va.

16 (a) Informant Louise Tucker
(b) Address 1236 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert G. Elliott
(b) Address 1019 N. Carolina St.

19 (a) (Date received by registrar) (b)

VS 10 AUG 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1944 at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5-44 1944, to 8-13 1944, and that I last saw h[illegible] alive on 8-13-1944.

Immediate cause of death Cerebral Thrombosis

Due to Hypertension

Due to

Other Conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1422 E. Chase Date signed 8-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a G19945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1030 Druid Hill
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1030 Druid Hill
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Hayes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1906

8. AGE: Years 38 | Months | Days | If less than one day hr. min.

9. Birthplace Arkansas (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Arkansas

MOTHER
14. Maiden Name unknown
15. Birthplace Arkansas

16 (a) Informant Rev. Hayes
(b) Address 1304 Wallace St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address Druid Hill

19 (a) (Date rec'd by registrar) (b) Huntington Williams

AUG 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1944 at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944 to Aug 14 1944 and that I last saw h[illegible] alive on Aug 14 1944

Immediate cause of death
Cardio Vascular Renal
Due to Uraemia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

Duration
5
9

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature D. D. Hughes M. D.
Address 1413 Druid Hill Ave Date signed Aug 15/44

VS 150

G19946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

Registered No. G19946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5212 St. Georges Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-10
(e) Length of stay in Baltimore (yrs., mos., or days) 60

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 5212 St. Georges Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Spahn

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Anna M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1862

8. AGE: Years	Months	Days	If less than one day
81	10	25	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name Peter Spahn
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Germany

16 (a) Informant Sophia Benham
(b) Address 5212 St. Georges Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/44 (month) (day) (year)
(c) Cemetery or crematory H. Rodgers
Location Belair Rd.

18 (a) Funeral director W. W. E. Dippell Sons
(b) Address 711 Belair Rd.

AUG 16 1944 (Date rec'd by registrar) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 14 1944 at 4P: M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1944 to Aug 14 1944, and that I last saw him alive on Aug 14 1944

Immediate cause of death	Duration
Hypertensive Cardio-Vascular disease	3 yrs
Due to Arteriosclerosis —	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at Work?
(e) Means of injury

23. Signature H. Henry Hargis M.D.
Address 5217 York Rd. Date signed 8/15/44

G19947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19947 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 631 W Lanvale st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 631 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex f | 5. Color or race w | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-16-1873

8. AGE: Years 70 | Months 8 | Days 29 | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name unknown
13. Birthplace

MOTHER 14. Maiden Name unknown
15. Birthplace

16 (a) Informant John H Brown
(b) Address 631 W. Lanvale st

17 (a) Burial (b) Date thereof 8-17-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Western Star
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 AUG 16 1944 (b) Huntington West Virginia
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944, at 7:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944, to Aug 14 1944, and that I last saw ... alive on Aug 14 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 2 days

Due to

Due to

Other Conditions Myocarditis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles H Mallet M. D.
Address 921 Park Ave Date signed Aug 16

G19948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G19948

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2333 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Mc Lomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
37			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Mc Lomas
13. Birthplace Middleton, Md

MOTHER
14. Maiden Name Mollie
15. Birthplace Baltimore, Md

16 (a) Informant Gladys Mc Lomas
(b) Address 204 N Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 16 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director McKatie R Williams
(b) Address 312 N Schroeder St

19 (a) (Date received by Registrar) AUG 16 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1944, at 9:20 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wounds of abdomen and neck

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 11, 1944 9:20 A M.
(b) Where did injury occur? Ramsay Ave & Baker
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed Aug. 17, 1944

G19949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G19949 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division Street

(c) Hospital or institution: Provident Hospital 11

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 112 E Center St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Susan Woods

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17 1879

8. AGE: Years 65 Months - Days 25 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation House-Maid

11. Industry or business

FATHER 12. Name John Henry Wood

13. Birthplace Charles Co, Md

MOTHER 14. Maiden Name Mary Jane Kelly

15. Birthplace Charles Co Md

16 (a) Informant Mrs Flossie King

(b) Address 2576 Madison Ave

17 (a) ✓ (Burial, cremation, or removal) (b) Date thereof 8-17-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Balto Md

18 (a) Funeral director Mrs Helen A. Holland

(b) Address 1631 Edmondson Ave

19 AUG 16 1944 (Date rec'd by registrar) (b) Huntington Ave Baltimore Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12 19 44, at 11 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10, 19 44, to August 12, 19 44, and that I last saw her alive on August 12, 19 44

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. L. Bamfield, M. D.

Address Provident Hospital Date signed 8/12/44

G19950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No. G19950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Rd
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Silver Spring
(If outside city or town limits, write RURAL and give town)
(d) Street No. Caverin College
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Brother Bernard Price, C. F. X.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 14, 1861

8. AGE: Years	Months	Days	If less than one day
83	1	1	hr. min.

9. Birthplace Nelson County, Kentucky
(Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER
12. Name John Riley Price
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary Spigel
15. Birthplace Kentucky

16 (a) Informant Mount Hope Retreat
(b) Address Baltimore 15 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof AUG. 17 1944 (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Eppes Sons Inc.
(b) Address 118 N. Mt. Royal Ave.

19 (a) (Signature of local registrar) (b) Huntington Williams M.D. Registered AUG. 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1944, at 3:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1944 to Aug. 15 1944, and that I last saw h[illegible] alive on Aug. 15 1944.

Immediate cause of death
Cerebral Hemorrhage — Duration 2 Days
Due to
Due to
Other Conditions Psychosis with arteriosclerosis — Duration ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Damian P. Hayes M. D.
Address 33 Hosp. Mt. Royal Ave. Signed

G19951

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

172 Registered No. G19951

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 96 N. Pulaski Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Brooks F. Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: married

6 (b) Name of husband or wife: Dorothy L. Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1915

8. AGE: Years 29 | Months 2 | Days 24 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Pipe shop

FATHER: 12. Name Robert R. Ross
13. Birthplace Balto. Md.

MOTHER: 14. Maiden Name Ethel Wenschof
15. Birthplace Pa.

16 (a) Informant Mrs. Dorothy L. Ross
(b) Address 96 N. Pulaski St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location 3900 Pedigree Ave

18 (a) Funeral director John Cowan & Son
(b) Address 901-03 Baltimore St

19 (a) (Date received by local registrar) (b) Huntington Williams, M.D. Registrar

AUG 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1944, at 8:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-14-44 at 3 P. M.
(b) Where did injury occur? Pier 7 - 1101 Key Highway
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? yes
(d) Means of injury Fell off boat into water

23. Signature Robert Lee Preston M.D. Medical Examiner.
Date signed Aug. 15 1944

G19952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 410 North Clinton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Clinton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Bradley

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Wm. E.
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1879

8. AGE: Years	Months	Days	If less than one day
64 63	109	27	hr. min.

9. Birthplace England (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Morgan
13. Birthplace England

MOTHER
14. Maiden Name Mary Morgan
15. Birthplace England

16 (a) Informant Wm. E. Bradley
(b) Address 410 N. Clinton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18, 44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Frederick Road

18 (a) Funeral director S. Walter Mary
(b) Address 619 N. Bouldin St.

19 (Date received by registrar) AUG 16 1944 Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION 20

20. DATE OF DEATH August 15 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy/Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Myocardial insufficiency cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Paul Howard Wallenmeyer Jr. M.D.
Medical Examiner.
Date signed 8-16-44

G19953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 181 ✓

G19953

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore, Maryland

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Township

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME David Bradley Wade

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 27-41

8. AGE: Years	Months	Days	If less than one day
2	9	20	hr. min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jacob Wayne

FATHER 13. Birthplace North Carolina

MOTHER 14. Maiden Name Mildred Sarvino

MOTHER 15. Birthplace Va.

16 (a) Informant Jacob Wayne

(b) Address Reisterstown Md

17 (a) Burial (b) Date thereof Aug 17-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Grace Cemetery

Location Balto. Co.

18 (a) Funeral director J.F. Elmer Sons

(b) Address Reisterstown Md

19 AUG 16 1944 (b) Huntington Williams, M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1944, at 2 A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Scald, trunk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-15-44 at 3 P. Balto Co. M.

(b) Where did injury occur? Phoenix, Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.

(d) Means of injury Pot of water accidentally overturned.

23. Signature H Z Wallenmeyer M.D.
Medical Examiner.

Date signed August 16, 1944

G19954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G19954 Registered No.

MARGIN RESERVED FOR BINDING

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Ditto marks may not be used. Abbreviations may be used except age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 618 S. Washington Street
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 S. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Krolczyk

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-3739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~of~~ Martin

6 (c) If alive, give age Deceased

7. Birth date of deceased (mo., day, yr.) Sept. 13 1875 ~~About 1875~~

8. AGE: Years	Months	Days	If less than one day
~~68~~ 69	11	1	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sabastian Brylewski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Unknown?
15. Birthplace Poland

16 (a) Informant Rose Hetmanski (Daughter)
(b) Address 2404 Fait Ave

17 (a) Burial (b) Date thereof 8-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A. Weber
(b) Address 705 South Ann Street

AUG 16 1944
(Date filed by registrar) Washington

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16th 1944 at 4 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944 to 8-15 1944 and that I last saw her alive on 8-15 1944

Immediate cause of death: Bron Pneumonia — Duration 3 Days

Due to: Condition below

Due to:

Other Conditions: Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Amelia S. Link

Address 2211 S Lake Date signed 8/16/44

(OVER)

G19955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19955 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3057 Parkhurst Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Charles C. Clark.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Florence O

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-10-1875

8. AGE: Years 68 | Months 11 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore. (Town, county, and state)

10. Usual Occupation Woodpattern Maker

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown.

16 (a) Informant Alvin Clark
(b) Address 2908 W. Lombard

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-14-49 (month) (day) (year)

(c) Cemetery or crematory Western
Location

18 (a) Funeral director L. J. Burch
(b) Address 5206 Harford Rd.

19 (a) Filed by registrar (b) Huntington Williamsport

AUG 16 1949

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-13- 1949 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13- 1949 to 8-13- 1949, and that I last saw h[illegible] alive on 8-13- 1949.

Immediate cause of death: Malignant Tuberculosis - Pathology. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles C. Macdonald M. D.
Address 1217 Light St. Date signed 8-15-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

a-11138

G19956 ✓ G19956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 587

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1031 Hanford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Janet Sims

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-5-38

8. AGE: Years	Months	Days	If less than one day
5	9	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Lish Sims
13. Birthplace S.C.

MOTHER
14. Maiden Name Dorsey Bailey
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/17/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Robert L. Gough
(b) Address 804 N. Carolina St.

19 (a) Huntington Williams, M.D. (Date received by registrar)

AUG 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944 at 3 45 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 6 1944 Aug 14 1944, and that I last saw h[illegible] alive on Aug 14 1944

Immediate cause of death	Duration
Heart failure	
Due to Rheumatic heart disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ellis Fear M. D.
Address Johns Hopkins Hosp. Date signed 8-14-44

G19957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 93D

G19957 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Glenburnie Nursing Home.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Manhattan Beach.
(If outside city or town limits, write RURAL and give town)
(d) Street No. A.O. Co. Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Louise Hackett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Widow

6 (b) Name of husband or wife James E. Hackett
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1877

8. AGE: Years	Months	Days	If less than one day
66	11	25	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER
12. Name Geo. W. Gardner
13. Birthplace Md.

MOTHER
14. Maiden Name Reinick
15. Birthplace Md.

16 (a) Informant Lt. Jas. Hackett
(b) Address 616 Linnard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 17 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk.
Location 3801 Fredrick Rd.

18 (a) Funeral director Harry H. Mitchell
(b) 1101 Edmondson Ave.
AUG 16 1944
(a) (b)
(Date rec'd by registrar) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 13/44, 19..., at 8.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1941 to Aug 13 1944 and that I last saw her alive on Aug 12 1944.

Immediate cause of death: Cardio-vascular hypertension disease — Duration: 6 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Homer L. Todd M. D.
Address 735 N. Fulton Ave. Date signed 8/15/44

G19958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19958

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil Co.
(c) City or town Perryville
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Crystal Bryant

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-16-06

8. AGE: Years 38 | Months 3 | Days - | If less than one day ..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Assembler - Martin

11. Industry or business

FATHER
12. Name Eugene Bryant
13. Birthplace Va

MOTHER
14. Maiden Name Ida Thulan
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Asbury Cem.
Location Perryville, Md. Rural

18 (a) Funeral director H. E. A. Patterson & Son
(b) Address Perryville, Md.

19 (a) ..... Registrar

Date received AUG 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1944 at 3:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1944 to Aug 16 1944 and that I last saw him alive on Aug 16 1944

Immediate cause of death	Duration
Sub acute bacterial endocarditis	
Due to Rheumatic heart disease	
Due to	
Other Conditions Acidosis terminal	

(Important contributory conditions not related to cause given in 21 (a) of death)

Date of operation.....

Major findings of operation:.....

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature John R. Birmingham M. D.
Address JHH Date signed 8/16

G19959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19959

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 DA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State PA. (b) County
(c) City or town YORK (If outside city or town limits, write RURAL and give town)
(d) Street No. 248 E. LIBERTY (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Forry

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	SINGLE

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 7, 1944

8. AGE: Years	Months	Days	If less than one day
	3	9	hr. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name WILLIAM FORRY
13. Birthplace PA.

MOTHER
14. Maiden Name IRENE GALLAHER
15. Birthplace PENNA.

16 (a) Informant ETZWEILER FUNERAL HOME
(b) Address YORK, PENNA.

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 8-16-44 (month) (day) (year)
(c) Cemetery or crematory
Location YORK, PA.

18 (a) Funeral director WM. J. TICKNER
(b) Address BALTO, MD.

AUG 17 1944 (b) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15 1944 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1944, to 8-15 1944, and that I last saw h.i.m alive on 8-15 1944.

Immediate cause of death: Respiratory Failure — Duration

Due to: Intracranial Injury

Due to:

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Lange M. D.
Address Univ. Hosp. Date signed 8-16-44

G19960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124

G19960 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 26 E Henrietta St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 26 E. Henrietta St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. 30 Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sue Jane Mason

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widow

6 (b) Name of husband or wife Samuel Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8 1874

8. AGE: Years	Months	Days	If less than one day
70	-	9	hr. min.

9. Birthplace Middlebrook Co Va (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Jim Snyder
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant C. H. Mason
(b) Address 26 E. Henrietta Balto Md

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cloverberry
Location Middlebrook Co Va

18 (a) Funeral director Earl L. Hess
(b) Address 715 Light St.

19 (a) (Date received by Registrar) (b) (Signature of Registrar)
AUG 17 1944 Huntington Mitchell, M.D.

VS 256

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1944 at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Aug 1944 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	weeks
Due to Hypertension	2 Yrs
Due to arteriosclerosis	"
Other Conditions Right Carotid acute Dilatation	5 days

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M. D.
Address 122 E. Madison St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR B...DING

G19961

329361

KRAUK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G19961 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 York Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Susie Krauk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William a.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-2-68

8. AGE: Years 76 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Joseph Rocker

13. Birthplace Md.

MOTHER 14. Maiden Name Mary Bowers ?

15. Birthplace Baltimore

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 17th (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004 N. Orleans St

19 AUG 17 1944 (Date received by Local Registrar) (b) Huntington Hillman M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1944, at 11.27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11- 1944 to 8-15- 1944 and that I last saw her alive on 8-15- 1944.

Immediate cause of death: Cardiac Failure — Duration

Due to: Arteriosclerotic Heart disease + generalized arteriosclerosis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lewis Dickson MD M. D.

Address Johns Hopkins Hosp Signed 8/17/44

G19962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G19962 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1937 E. Fairmount Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Robert Lee Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 4 1944

8. AGE: Years	Months	Days	If less than one day
	7	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Raymond Smith

13. Birthplace

MOTHER 14. Maiden Name ? ?

15. Birthplace

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 18/44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Bachelors

Location Frederick Rd

18 (a) Funeral director Geo M. Smith & Son

(b) Address 811 N Wolfe St

Date rec'd AUG 17 1944 (b) Huntington Williams 1st

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 15 1944 at 7.27 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 15 1944 to Aug - 15 1944 and that I last saw him alive on Aug - 15 1944.

Immediate cause of death Dehydration Respiratory Failure — Duration 3 Days

Due to Summer Diarrhea

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Leonard Joel Koenig M. D.

Address Johns Hopkins Hosp Date signed

G19963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G19963 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 004
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 251 S. Bouldin Street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Marcello Castellazzi

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Ermenegilda Castellazzi
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 1881

8. AGE: Years	Months	Days	If less than one day
63	1	25	hr. min.

9. Birthplace Castigliana Veronese Italy (Town, county, and state)
10. Usual Occupation Cabinet Maker
11. Industry or business

FATHER
12. Name Antonio Castellazzi
13. Birthplace Italy

MOTHER
14. Maiden Name Luigia Zanotti
15. Birthplace Italy

16 (a) Informant Ermenegilda Castellazzi (Wife)
(b) Address 251 S. Bouldin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 18/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cemetery
Location Belair Rd. Baltimore Md.

18 (a) Funeral director Frank Della Noce
(b) Address 52 N. Morley St.

19 AUG 17 1944 (b) [illegible] Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 45, at 9 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] M.D. Medical Examiner
Date signed Aug 15, 1944.

19964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46d

Registered No. G19964

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Calvert
(c) Hospital or institution: U.M.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #7 (If outside city or town limits, write RURAL and give town)
(d) Street No. 4008 Liberty Heights (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Henry Singer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Jewish | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rachel Singer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18 1884

8. AGE: Years 60 | Months - | Days 28 | If less than one day hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation Cutter Cigarmfg
11. Industry or business

FATHER
12. Name Jacob Singer
13. Birthplace Russia

MOTHER
14. Maiden Name Leah Lips
15. Birthplace Russia

16 (a) Informant Rachel Singer
(b) Address 4008 Liberty Hgts Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6-17-44 (month) (day) (year)
(c) Cemetery or crematory Sinai Israel
Location Druid Lane Balto
18 (a) Funeral director Jack Levin Inc
(b) Address 443 E. Balto St

(a) Date received AUG 17 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1944 at 10:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1944 to Aug 16 1944 and that I last saw h[illegible] alive on Aug 16 1944

Immediate cause of death: Cystitis Thrombosis — Duration

Due to

Due to

Other Conditions Double Cataract, Diabetes Mellitus, Reaction of GU tract

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Lee Mongan Jr. M.D.
Address 332 W. University Pkwy Date signed 8/16/44

G19965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G19965 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33-A W Calvert
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 Eutaw Pl. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Annie Rae Swope Guard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife James K. Guard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-21- 1873

8. AGE: Years 70 | Months 10 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace PENNSYLVANIA (Tyrone)
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER 12. Name Mr. GRANVILLE H. Swope
13. Birthplace PENNSYLVANIA

MOTHER 14. Maiden Name Emma Buckingham
15. Birthplace Pennsylvania

16 (a) Informant Mr. James K. Guard
(b) Address 1123 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) AUG 17 1944 (Registrar)

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1944, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1944, to 8-16 1944, and that I last saw her alive on 8-16 1944.

Immediate cause of death	Duration
CARDIO-RESP. FAILURE	
Due to Metastases	
Due to CARCINOMA of Sigmoid Colon	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Morris M. D.
Address 1 W Mt Date signed 8-16-44

G19966 BALTIMORE CITY HEALTH DEPARTMENT 93 G19966

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3100 Windsor Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Windsor Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIJAH L. BANGS

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Alverta Bangs
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 13, 1863
8. AGE: Years 81 | Months 0 | Days 2 | If less than one day hr. min.
9. Birthplace Wilmington, Del. (Town, county, and state)
10. Usual Occupation Retired Historian
11. Industry or business B. & O. R. R.

FATHER
12. Name Eli Bangs
13. Birthplace ?

MOTHER
14. Maiden Name Esther Lewis
15. Birthplace ?

16 (a) Informant Mr. Howard L. Bangs
(b) Address 2107 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) AUG 17 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1944, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Aug 15 1944, and that I last saw him alive on Aug 15 1944.

Immediate cause of death	Duration
Dry gangrene of left foot and leg below knee	3 weeks
Due to Advanced arterio sclerosis and poor arterial Circulation	?
Other Conditions Hypocondria	2 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter S. Tibbitt M. D.
Address 2220 Harrison Blvd Date signed Aug 16/44

G19967 BALTIMORE CITY HEALTH DEPARTMENT 1310 G19967

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 E. 33rd. Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 E. 33 St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Terasino

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sarah

6 (c) If alive, ~~May 5 1882~~

7. Birth date of deceased (mo., day, yr.) ~~May 5, 1879~~

8. AGE: Years ~~65~~ 62 | Months 3 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Fruit Dealer

11. Industry or business

FATHER
12. Name Joseph Terasino
13. Birthplace Italy

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Sarah Terasino
(b) Address 1611 E. 33rd. Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 18 44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road

18 (a) Funeral director Joseph Farace Ins.
(b) Address 2012 Pennsylvania Ave

19 (a) ..... (b) ..... (Date received by registrar) Registrar

AUG 17 1944

VS 180

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16- 1944; at 5A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6 1944 to 8-16 1944 and that I last saw h. alive on 8-16 1944

Immediate cause of death Uremia. — Duration 10 days

Due to Chronic nephritis. — Duration 4 yrs

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operations: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....

23. Signature S. Standard M. D.
Address Medical Arts Bldg Date signed (over)

G19968

1 Trans.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 14

✓ G19968

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1703 E. Eager St (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country.....

3 (a) FULL NAME Alberta Willingham

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-18-30

8. AGE: Years	Months	Days	If less than one day
13	10	29	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER — 12. Name Albert Willingham

13. Birthplace Ga.

MOTHER — 14. Maiden Name Hattie Jennings

15. Birthplace Ga.

16 (a) Informant Leonards.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem

Location A. A. County Md

18 (a) Funeral director Mrs Robert H Eichelberger

(b) Address 129 N. Carlton St.

AUG 17 1944 (Date received by Registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 19 44 at 8.50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944 to Aug 16 1944 and that I last saw h[illegible] alive on Aug 16 19 44

Immediate cause of death ..... Duration

Circ. collapse .....

Due to Tbc meningitis .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature Leonard Joel Koenig M. D.

Address Johns Hopkins Hosp Date signed 8-16-44

G19969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19969 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 N. Luzerne Ave.
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Luzerne
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Petro D. Costello

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-16-85

8. AGE: Years 59 | Months 7 | Days ~ | If less than one day hr. min.

9. Birthplace ITALY (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name
13. Birthplace Not obtained

MOTHER
14. Maiden Name "
15. Birthplace

16 (a) Informant Hospital Chart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Frank Dalby Hoce
(b) Address 322 S. High St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 17 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1944 at 7 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1944, to 8-16 1944 and that I last saw him alive on 8-16 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan E Chesdi

Address St Joseph Hospital signed 8/16 1944 D.

G19970 BALTIMORE CITY HEALTH DEPARTMENT G19970
CERTIFICATE OF DEATH 83d Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St
(c) Hospital or institution: Home for Incurables 136
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4yr-2mo-22da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W. 40th St (If rural give location)
(e) Citizen of foreign country? [illegible] (Yes or No) If yes, name country NO

3 (a) FULL NAME (ANNIE) Ann Holmes Whitley

3 (b) If veteran, name war NONE | 3 (c) Social Security Account No. NONE

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age [illegible] years

7. Birth date of deceased (mo., day, yr.) Aug 8 - 1854

8. AGE: Years: 90 | Months: 0 | Days: 8 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Deaconess

11. Industry or business

FATHER
12. Name William S. Whitley
13. Birthplace Whitelaysville - Md

MOTHER
14. Maiden Name (EMMA) Emily Holmes
15. Birthplace Phila - Pa

16 (a) Informant H. LaRue Brauning
(b) Address 700 W. 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) [illegible] (Date rec'd by registrar) (b) [illegible] Registrar

AUG 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 16 - 1944 at 8:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5/25 1940 to 8/16 1944 and that I last saw h[illegible] alive on 8/15 1944

Immediate cause of death: Hemiplegia (Left) — Duration: 8 Days.

Due to: Arteriosclerosis (Hem.) — 25 yrs

Due to: Hypertension (Essential) Nephr. — 20 yrs

Other Conditions Contrib: Hypertrophy of Ventricle — 15 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Grafton Thompson
Address 214 Medical Bldg Date signed 8/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G19971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170 G19971 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Pennsylvania Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Han Sing

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male

5. Color or race: Chinese

6 (a) Single, married, widowed, or divorced: Don't Know

6 (b) Name of husband or wife: ? ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years: 48 Months: Days: If less than one day hr. min.

9. Birthplace: Don't Know (Town, county, and state)

10. Usual Occupation: —

11. Industry or business: —

FATHER
12. Name: Don't Know
13. Birthplace " "

MOTHER
14. Maiden Name: Don't Know
15. Birthplace " "

16 (a) Informant: Mrs. S. Bock (friend)
(b) Address: 416 Southway, City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18/44 (month) (day) (year)

(c) Cemetery or crematory: Lorraine
Location: Woodlawn, Md.

18 (a) Funeral director: Stewart & Monument Co.
(b) Address: 108-W. North Ave.

19 (a) AUG 17 1944 (Date rec'd by registrar) (b) Huntington Mills, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1944, at 5:20 A. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ✓, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hemorrhage gastric

Due to Gastric ulcer

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed August 14 1944.

G19972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19972

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Wilkens Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Sophia Stranz

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Husband - Edward

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 7-8-1895

8. AGE: Years 49 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business HOME

FATHER
12. Name deceased
13. Birthplace

MOTHER
14. Maiden Name Augusta TREOCHEL
15. Birthplace GERMANY "LIMPERT"

16 (a) Informant EDWARD STRANZ
(b) Address 2508 WILKINS AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-19-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVE

18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1026 REEDS AVE.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 AUG 17 1944 Washington, Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1944 at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1944 to 8/16 1944 and that I last saw her alive on 8/16 1944

Immediate cause of death
Cardiac failure
Due to Hemorrhage
Due to Abdominal Cancer
Other Conditions Rectal

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Brophy M. D.
Address St. Agnes Hosp Signed 8-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G19973

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: 614 S. Charles Street

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 614 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1944

8. AGE: Years | Months: 2 | Days: 15 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Trentress Thomas
(b) Address 614 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director G. Halstead
(b) Address 916 Druid Hill Ave

19 (a) AUG 17 1944 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1944, at 3 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, lobular
primary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williamson M.D.
Medical Examiner.
Date signed August 16, 1944

G19974 ✓ G19974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1044 Shields Pl (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore md (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Wilkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: wpe | 6 (a) Single, married, widowed, or divorced: baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1944

8. AGE: Years | Months: 4 | Days: 14 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Daniel Wilkens
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Wilson
15. Birthplace Md

16 (a) Informant Carrie Wilson
(b) Address 1044 Shields St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 (month) (day) 1944 (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) Huntington for Williams, M.D. Registrar

AUG 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1944, at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1944, to Aug 16 1944, and that I last saw h[illegible] alive on Aug 16 1944.

Immediate cause of death Cranio Cerebro-Lesion | Duration
Due to
Due to
Other Conditions Malnutrition
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. W. Bamfield
Address Provident Hospital Date signed 8/7/44 M. D.

G19975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131b ✓

Registered No. G19975

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave. 29
(c) Hospital or institution: St. Agnes Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Rosecroft Ter. 29 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William T Rush

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation merchant
11. Industry or business

FATHER
12. Name Lewis Rush
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Lamar
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Margaret Rush
(b) Address 417 Rosecroft Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave. Balto Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave. Huntington Station, N.Y.

AUG 17 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1944, 9:25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1944 to 8-16 1944 and that I last saw him alive on 8-16 1944.

Immediate cause of death Uremia — Duration
Due to Chronic Glomerulo-nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.
Address St. Agnes Hosp Date signed 8-16-44

G19976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19976 Registered No. 2420

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Darley Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HENRY NAUMANN

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 214-01-2989

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Carrie Marie

6 (c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): May 4, 1898

8. AGE: Years 46 | Months 3 | Days 11 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md
(City, county, and state)

10. Usual Occupation: Chauffeur

11. Industry or business: Laundry

FATHER
12. Name: August John Naumann
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden Name: Anna Frederick
15. Birthplace: Baltimore, Md

16 (a) Informant: Mrs. Charles H. Naumann
(b) Address: 1736 Darley Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8- 18- 44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cem
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc
(b) Address: North Ave. & Broadway

19 (a) (Date received by Registrar) AUG 17 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14-44 19 , at 11 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1944, to 8-14 1944, and that I last saw h[illegible] alive on 8-14 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Hypertensive Cardio-vascular Disease

Due to:

Other Conditions: Lauren's Cirrhosis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None or stated

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H. S. Amrich M. D.
Address: Sinai Hosp Date signed 8-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

G19977

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3/a

G19977
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1638 Carswell St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 Carswell St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward H. Murgatroyd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Birdella McCulloh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 25, 1875

8. AGE: Years	Months	Days	If less than one day
69	2	20	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation watchman
11. Industry or business Johnson Radio Co

FATHER
12. Name George
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name not known
15. Birthplace Frederick Md,

16 (a) Informant Wife
(b) Address 1638 Carswell St.

17 (a) Burial (b) Date thereof 8/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) AUG 17 1944 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14th. 1944., at 2:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-29- 1944. to 8-14 1944. and that I last saw him alive on 8-13 1944.

Immediate cause of death	Duration
Uremia	2 days
Due to Chronic Interstitial Nephritis	unknown
Due to ----------	
Other Conditions Endocarditis	about 2 mos.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas W Murgatroyd MD
Address 401 E. 25th. St. Date signed 8/16/44.

G19978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10 S. Patterson Park Ave 93d

G19978 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 S. Patterson Park Ave
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Michalaki

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W Dutch

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug 10 1858

8. AGE: Years 86 | Months - | Days 5 | If less than one day ... hr. ... min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Kupinski
13. Birthplace: Poland

MOTHER
14. Maiden Name: unknown
15. Birthplace: Poland

16 (a) Informant: Mrs. Saylor
(b) Address: 3608 Frankland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary Cem
Location: Baltimore County

18 (a) Funeral director: John M. Welby
(b) Address: 406 S. Chester Street

19 (a) [illegible] (Date rec'd by registrar) (b) Huntington Maryland, M.F.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1944, at 6 39 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
Cardio Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature: Robert Lee Graham M.D.
Medical Examiner.
Date signed Aug. 15, 1944

315655

G19979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

16

G19979
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Odenton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Eades

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-28-10

8. AGE: Years	Months	Days	If less than one day
34	-	18	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Sam Eades
13. Birthplace ?

MOTHER
14. Maiden Name Marie ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)
(c) Cemetery or crematory Church St
Location Odenton Md

18 (a) Funeral director Isaiah L Brumbley
(b) Address R.F.D. Millersville, Md.

19 (a) AUG 17 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15 1944 at 3:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1944 to Aug 15 1944 and that I last saw h[illegible] alive on Aug 15, 44

Immediate cause of death

	Duration
Tuberculosis Meningitis	3 wks
Due to	
Due to	
Other Conditions Tuberculosis of spine. ? Tbc Pneumonia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Benesen
Address J. Hopkins Date signed 8-25 M. D.

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G19980 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462 ✓ G19980

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 W Hamburg
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 W Hamburg (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Valentine

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife

6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) April 2 [illegible]

8. AGE: Years 58 | Months 4 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Cross Hill Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Willis Castleberry

13. Birthplace Md

MOTHER 14. Maiden Name [illegible] Callaway

15. Birthplace [illegible]

16 (a) Informant [illegible] Smith

(b) Address [illegible] W Hamburg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Balto City

18 (a) Funeral director Isaac L Brown Sons

(b) Address 108 W Monument St

19 (a) (Date received) AUG 17 1944 (b) [illegible] Baltimore, Md

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944, at 5:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Aug 14 1944 and that I last saw h[illegible] alive on Aug 14 1944

Immediate cause of death [illegible] Carcinoma of Ovaries

Due to Carcinoma of Ovaries

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Homer M. D.

Address 402 Edmondson Date signed 8/16

G19981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100b ✓ Registered No. G19981

Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 255 N. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Krublewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-05-0157

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Marijanna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1891

8. AGE: Years	Months	Days	If less than one day
52	10	1	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business Baker

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace Poland

16 (a) Informant Josephine Porcella
(b) Address 1831 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Gorsuch Hill Rd.

18 (a) Funeral director M. W. E. Diggs Sons
(b) Address Lombard & Gay Sts.

19 (a) Date received AUG 17 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1944 at 9:45 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Thrombophlebitis, chronic left leg, gangrenous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed August 16, 1944.

G19982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G19982

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since July 17, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since July 17, 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Edgewood (If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES UPTON SMITH

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. -

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1889

8. AGE: Years 55 | Months 6 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Gas Patrol Guard 1943
11. Industry or business Edgewood Arsenal

FATHER
12. Name Joseph R. Smith
13. Birthplace Pa.

MOTHER
14. Maiden Name Carrie Ann Taylor
15. Birthplace Carroll Co., Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Bette National
Location Frederick Co.

18 (a) Funeral director A. Lee Odey
(b) Address 4644 York Rd.

AUG 17 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16, 1944, at 12:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17, 1944 to Aug. 16, 1944, and that I last saw him alive on Aug. 16, 1944

Immediate cause of death Peritonitis; cirrhosis of the liver; Splenomegalia — Duration: Unk.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 7/19/44-Abdominal paracentesis 8/7/44-Insertion glass [illegible] spool abdominal wall- Colored fluid removed.
Findings: Cirrhosis of liver
Microscopic or autopsy findings — As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Philip L. Spencer M. D.
Address Baltimore, Md. Date signed 8/16/44

Va-14523

G19983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G19983 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Maryland
(b) Street address
(c) Hospital or institution: Providence Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 N. Howard Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert W. Gardner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 16th 1926

8. AGE: Years 17 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Sparks Md. Balto. Co. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Gardner
13. Birthplace Sparks Md Balto co

MOTHER
14. Maiden Name Hattie Powell
15. Birthplace Sparks Md Balto co

16 (a) Informant Hattie Gardner
(b) Address 2128 N. Howard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 17 1944 (month) (day) (year)
(c) Cemetery or crematory Quaker Bottom
Location Md, Balto co.

18 (a) Funeral director Byron Thomas W. Wright
(b) Address 729 Aliceanna St

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

AUG 17 1944 VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1944, at 2:25 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Gangrene of intestine
Due to Stab wound of abdomen.
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-8-44 at 11 15 P M.
(b) Where did injury occur? In front of 2209 N. Howard
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
Means of injury Knife (?)

23. Signature H. L. Wallenweber M.D. Medical Examiner.
Date signed August 14, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G19984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 76a

Registered No. G19984

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Presbury St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Colvin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years	Months	Days	If less than one day
27	26		hr. min.

9. Birthplace Clinton, N.C.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Clinton, N.C.

MOTHER
14. Maiden Name Not Known
15. Birthplace Clinton, N.C.

16 (a) Informant Josephine Colvin
(b) Address 1616 Pusbury St.

17 (a) Burial (b) Date thereof 8/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fellingston N.C.
Location North Carolina

18 (a) Funeral director Ney D. Kelly
(b) Address 1303 Preastman St

19 (a) (b)
(Date received by registrar) Huntingtown, West Virginia

AUG 17 1944

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1944, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1944, to 8-14 1944, and that I last saw her alive on 8-14 1944.

Immediate cause of death	Duration
a. agranulocytosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: a
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D Lyon M. D.
Address University Hosp Date signed 8-17-44

45 G19985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19985 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State W Va (b) County

(c) City or town Roncevert (If outside city or town limits, write RURAL and give town)

(d) Street No. 602 Roncevert Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Herbert Harr

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Minnie

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 4-13-89

8. AGE: Years 55 | Months 4 | Days 3 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business

FATHER

12. Name Rawley Harr

13. Birthplace W. Va

MOTHER

14. Maiden Name Elizabeth Griffin

15. Birthplace W. Va.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 16/44 (day) (year)

(c) Cemetery or crematory Rosemont Cem. Location Keyser W Va

18 (a) Funeral director John B Mitchell Undertaker

(b) Address 1900 Eastern Place

19 (a) AUG 17 1944 (Date received by registrar) Registrar

VS 156

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August - 16 1944, at 10.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 9 1944, to Aug - 16 1944, and that I last saw him alive on Aug - 16 1944.

	Duration
Immediate cause of death Paralytic ileus & Acute dilitation of Stomach	
Due to post-operative prostatectomy	
Due to Benign Prostatic hypertrophy	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation 8-9-44

Major findings of operation: Benign prostate hypertrophy

of autopsy: Nothing significant

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph C. Presto

Address Johns Hopkins Hosp Date signed 8-17-44 M. D.

G19986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1644

✓ G19986

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Baltimore Md.
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 N. Payson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse Lowe Carter

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace Carter

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1876

8. AGE: Years	Months	Days	If less than one day
68	4	0	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Retired 6 yrs.

FATHER
12. Name John Carter
13. Birthplace N. C.

MOTHER
14. Maiden Name Alberta Hopkins
15. Birthplace Md.

16 (a) Informant Mrs. Grace Carter
(b) Address 1917 N. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed AUG 17 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1944, at 7.50 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Suicide Hanging by Rope

Due to Mental Despondency

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-16-44 at 7 A. M.
(b) Where did injury occur? 1907 N. Payson Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home - Cellar While at work? No.
(d) Means of injury Hanging by rope in cellar

23. Signature J. L. Wallenmeyer M.D. Medical Examiner.
Date signed August 16, 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 P

Registered No. G19987

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Lt Quitaque Landing (If outside city or town limits, write RURAL and give town)
(d) Street No. Severna Park (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME J. Mildred Bowman

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: —

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: W. A. Bowman

6 (c) If alive, give age 4 years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1896

8. AGE: Years 48 | Months 6 | Days 2 | If less than one day: hr. min.

9. Birthplace Ohio (Newcomerstown) (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Hill
13. Birthplace Ohio

MOTHER
14. Maiden Name Smith
15. Birthplace Ohio

16 (a) Informant W. A. Bowman
(b) Address Lt Quitaque Landing Severna Park Md

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/17/44 (month) (day) (year)

(c) Cemetery or crematory
Location Pittsburgh, Pa.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 17 1944 Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/ 1944 at 10.40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13/ 1944 to 8/17 1944 and that I last saw her alive on 8/17 1944.

Immediate cause of death	Duration
Dementia	
Due to Peritonitis	
Due to Gangrenous Bowel	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/16/44

Major findings of operation: Gangrenous Bowel & Bowel adherent to Cancer of ovary; obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cliff Ratliff Jr. M. D.
Address University Hosp. Date signed 8/17/44

G19988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G19988 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert Sts.
(c) Hospital or institution: Mercy Hosp. W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 67 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 Wash. Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Camella

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-09-8317

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Wid

6 (b) Name of husband or wife late Mary A Camella
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) January 1877.

8. AGE: Years	Months	Days	If less than one day
67	2	2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Doorman.

11. Industry or business Picture Theatre

FATHER
12. Name ? Frank Camella
13. Birthplace Italy

MOTHER
14. Maiden Name ? Unknown.
15. Birthplace Germany

16 (a) Informant Jay Cie West. Undertaker
(b) Address 1128 Wash Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem
Location 43 00 Old Fred Rd.

18 (a) Funeral director John F Downey & Son
(b) Address 901 Hollins St.

19 (a) (Date received by registrar) (b) (Registrar)

AUG 17 1944 Huntington Maryland

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16. 1944, at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1944 to 8/16 1944 and that I last saw him alive on 8/16 1944

Immediate cause of death	Duration
Resp Fail.	
Due to Edrimia & Hyper-Tensive Cardio.	3-4 wk.
Due to Renal Dis.	?
Other Conditions Bursitis of Knee	?
due to fall.	✓

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 23, 1944 P. M
(c) Where did injury occur? Sherwin Oak Park
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public While at work? no
(Specify type of place)
(e) Means of injury fell over tree stump.

23. Signature M. Jane Foley M.D.

Address Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19989 ✓ G19989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Parkside ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ralph Aniunas ANIUNAS

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. 155-09-0255

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Veronica

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Gas Station

11. Industry or business

FATHER 12. Name ?

13. Birthplace Lith

MOTHER 14. Maiden Name

15. Birthplace Lith

16 (a) Informant Casmir Aniunas

(b) Address South Plainfield N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 21 44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer Cem.

Location Plainfield N.J.

18 (a) Funeral director Joseph Caudakas Sons

(b) Address 606 Washington Blvd

19 (a) AUG 17 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1944 at 12 00 N

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1944 to 8-17 1944 and that I last saw h/A alive on 8-17 1944

Immediate cause of death Coronary Hemorrhage

Due to Carcinoma of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. MacDonald M. D.

Address 1213 Light St Date signed 8-17-44

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G19990
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 425 S Payson St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Bourke

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Winifred Bourke
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Dec. 15th 1895

8. AGE: Years	Months	Days	If less than one day
48	8	—	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Saloon Keeper.
11. Industry or business

FATHER
12. Name John Bourke
13. Birthplace Ireland.

MOTHER
14. Maiden Name Ellen Hughes
15. Birthplace Ireland.

16 (a) Informant Winifred Bourke
(b) Address 425 S. Payson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18th 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E Fort Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport

AUG 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1944 at 5:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Aug 15 1944, and that I last saw h. alive on Aug 15 1944

Immediate cause of death Carcinoma of Pancreas — Duration 6 Mos

Due to

Due to Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation March 1944
Major findings of operation: Carcinoma of Pancreas
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. F. Alagia M. D.
Address 3326 Gilmore Date signed 8/17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be furnished if it is known to the informant. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19991 ✓ G19991 Registered No.

94a

G19991

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7816 Hamilton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 7816 Hamilton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Homer Hixon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Wd

6 (b) Name of husband or wife Mildred E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 10 1862

8. AGE: Years 61 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace New Jersey (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Abraham Hixon
13. Birthplace

MOTHER
14. Maiden Name Emma Cole
15. Birthplace Ky

16 (a) Informant Mrs Mildred E. Hixon
(b) Address 7816 Hamilton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 44 (month) (day) (year)
(c) Cemetery or crematory Easton N.J.
Location

18 (a) Funeral director L. J. Rusk
(b) Address 2205 Huntington Ave Balto Md

19 (a) AUG 17 1944 (Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1944 at 3:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943 to Aug 16 1944 and that I last saw h. alive on Aug 14 44

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Coronary Heart Disease	1 yr.
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George Dawson M. D.
Address 4808 Harford Rd. Date signed 8/7/44

G19992 BALTIMORE CITY HEALTH DEPARTMENT XV G19992
Registered No.

CERTIFICATE OF DEATH 36

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanford Rd
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore Co.
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Willoughby Ave (If rural give location) Rockville
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Charles Potts

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7, 1936

8. AGE: Years 8 | Months 1 | Days 89 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name William J. Potts
13. Birthplace Md.

MOTHER 14. Maiden Name Mildred Schneider
15. Birthplace Md.

16 (a) Informant Father
(b) Address 3030 Willoughby Ave

17 (a) Burial (b) Date thereof Aug 18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford

19 (a) AUG 17 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1944, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1944, to 8/16 1944, and that I last saw h-- alive on 8/16 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Bulbar Poliomyelitis	1 day
Due to	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation 8/16/44
Major findings of operation: Medulla Hemorrhage
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret H D. Smith M. D.
Address Sydenham Hosp Date signed 8-17

G19993 | BALTIMORE CITY HEALTH DEPARTMENT | G19993

CERTIFICATE OF DEATH

937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2920 Cheeley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2920 Cheeley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Francis Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W	widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Foreman Balto City Water System

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry L Malbon
(b) Address 2920 Cheeley Ave. Baltimore

17 (a) Burial (b) Date thereof 8-19-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location

18 (a) Funeral director Leonard L Rusk
(b) Address 5305 Harford Rd Baltimore MD

AUG 17 1944

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 6 1944 to Aug 16 1944 and that I last saw him alive on Aug 13 1944

Immediate cause of death Coronary thrombosis — Duration Sudden

Due to Chronic myocarditis

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harbold

Address 4706 Harford Rd Date signed 8/19/44

G19994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G19994 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 E. 20th st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 E. 20th st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Hinchliffe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, ~~widowed or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Elizabeth Hinchliffe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 12th 1864

8. AGE: Years	Months	Days	If less than one day
80	5	4	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Textile Worker

FATHER
12. Name Joseph Hinchliffe
13. Birthplace England

MOTHER
14. Maiden Name Mariah Lobley
15. Birthplace England

16 (a) Informant Elizabeth Hinchliffe
(b) Address 408 E. 20th St.

17 (a) Removal (b) Date thereof 8/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hillside
Location Phila. Pa.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date received by registrar) (Huntington Williams M.D. Registrar)

AUG 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16th 1944, at 1:30 a.m. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to Aug 14, 1944, and that I last saw h~~im~~ alive on Aug. 14 1944

Immediate cause of death Uremia — Duration 1 wk.
following prostatectomy
at Lutheran Hospt.
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation June 20, 1944
Major findings of operation: Hypertrophied prostatitis. Dr. Toulson
of autopsy: Same.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. W. Guyton, M.D.
Address 3963 Greenmount Ave. Date signed 8/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

19995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

G19995 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1624 Tokn st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Tokn st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Jacob S. Eyerly

3 (b) If veteran, name war 1o | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara A. Eyerly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12th 1881

8. AGE: Years 63 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Balto. Transit Co.

FATHER 12. Name Charles Eyerly

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Annie (Unknown)

15. Birthplace Balto. Md.

16 (a) Informant Clara A. Eyerly

(b) Address 1624 Tokn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Location Md.

18 (a) Funeral director William Cook Jun.

(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) AUG 18 1944 (b) Huntington Millington, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17th 1944, at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944, to Aug. 17 1944, and that I last saw h. alive on Aug 17 1944.

Immediate cause of death

Cancer Stomach (Pylorus and)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 months

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Everett R. Mortimer M. D.

Address 2700 St Paul St Date signed 8/17/44

G19996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G19996 Registered No.

MD.perAB 15770

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21yrs- 6mos. 14days
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

26 17

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (Balto.City Hosp.)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Greiner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.-3-1860

8. AGE: Years 83 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Factory Work

11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave. (Records)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 18 1944 (Date rec'd by Registrar) (b) Howard J. Williams, M.D. Registrar

VS 156

For S.H.D. Problem number 2085 by Howard J. Andrews, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 9- 1944, at 3.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1943, to 8-9 1944, and that I last saw her alive on 8-8 1944

Immediate cause of death	Duration
Congestive Heart Failure	
Due to Hypertension - C-V.D.	
Due to	
Other Conditions Non-Unions of Rt Femoral Fracture	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence OCTOBER 6-1943 at 1:30 P.M
(c) Where did injury occur? 4940 Eastern Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? -no-
(e) Means of injury Subtrochanteric Fracture of Right Femur; Patient fell to floor;
23. Signature H. Greiner M.D.
Address 4940 Eastern Ave Date signed 8-16-44

G19997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G19997

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 954 - Forrest St

(c) Hospital or institution: Maryland Penitentiary Hospitals 12

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days

(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Baltimore 5

(If outside city or town limits, write RURAL and give town)

(d) Street No. 105 - West 20th St

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Brown (#2)

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7, 1907

8. AGE: Years 37 | Months 5 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation book

11. Industry or business

FATHER — 12. Name Frank Brown

13. Birthplace Virginia

MOTHER — 14. Maiden Name Lucy Brown

15. Birthplace Virginia

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 17 1944

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 18 1944 (Date received by Registrar) Hunter Scott Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 1944, at 11:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to July 29 1944, and that I last saw h[illegible] alive on July 29 1944.

Immediate cause of death	Duration
Hypertensive cardiovascular renal disease	
Cerebral hemorrhage	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. F. Harris M. D.

Address Md. Pen. Hospitals Date signed 7-30-44

2084

G19998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G19998 Registered No. 130

WO #68527

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Timothy Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1893

8. AGE: Years 51 | Months -1- | Days -6- | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Thomas
13. Birthplace North Carolina

MOTHER
14. Maiden Name Polly Dickens
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 18 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1944, at 8:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 14, 1944 to Aug. 10, 1944, and that I last saw him alive on Aug. 10, 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl R. Kenney M. D.
Address B. C. H. Date signed 8/22/44

2083

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G19999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No. G19999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 N. Gilmor (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME EDWARD FOSTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 65 | Months | Days | If less than one day .....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation.....
11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL AUG 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address.....

AUG 18 1944 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 6, 1944, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?.....While at work?.....
(d) Means of injury.....

23. Signature H. J. Wollamsaber M.D.
Medical Examiner.
Date signed 8-6-44

2086

THE MORGUE MARC RESERVED FOR STAMPING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20000

BALTIMORE CITY HEALTH DEPARTMENT 94a

CERTIFICATE OF DEATH

Registered No. G20000

Home address - Spain

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 N. Bond St. - 3rd fl.
(If rural give location)
(e) Citizen of foreign country? Spain (Yes or No)
If yes, name country

3 (a) FULL NAME Ramon Madariaga

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 60 | Months | Days | If less than one day ....hr. ....min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 16 1944

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 18 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30- 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Malloy M.D.
Medical Examiner.

Date signed 7-31-44

2087

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G20001 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 Etting St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Etting St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levi Gorman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1876

8. AGE: Years	Months	Days	If less than one day
67	7	21	hr. min.

9. Birthplace Carroll Co. Md (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Gorman
13. Birthplace Carroll Co., Md.

MOTHER
14. Maiden Name Elizabeth —
15. Birthplace Carroll Co. Md.

16 (a) Informant Louise Gorman
(b) Address 1916 Etting St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location Baltimore Md.

18 (a) Funeral director Archibald R. Gaddis
(b) Address 2101 McCulloh St.

AUG 18 1944 (Date rec'd by registrar)

(b) Huntingtown, Calvert Co., Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1944, at 1:20 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, inspection or inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocarditis degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Aug. 17 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Use the terms of the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

VS 151

G20002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 C

G20002 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5605 Carter Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Carter Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine McInnis

3 (b) If veteran, name war None | 3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm A. Quinn | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 12, 1902

8. AGE: Years 42 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home work

11. Industry or business at Home

FATHER 12. Name James B. Birch
13. Birthplace England

MOTHER 14. Maiden Name Mary Appleton
15. Birthplace Ireland

16 (a) Informant Wm. A. Quinn
(b) Address 5605 Carter Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19/44 (month) (day) (year)
(c) Cemetery or crematory Mount Cathedral Cemetery
Location 4300 Old Frederick Rd

18 (a) Funeral director Edmund W. Cookman & Son
(b) Address 924 E. Eager St. Balto 2, Md.

19 (a) (Date received) AUG 18 1944 (b) Registrar's Address Huntington Avenue Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16th 1944 at 8 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27 1944 to Aug 16 1944 and that I last saw h. alive on Aug 15 1944.

Immediate cause of death	Duration
Broncho Cardiac Insufficiency	1 hr
Due to Endocarditis	15 yrs
Due to Rheumatic Fever	15 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred L Zimmermann Address 2958 Hackwood Date signed 8/17/44

G20003

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20003 Registered No.

CERTIFICATE OF DEATH 131a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1205 Valley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Boegner
3 (b) If veteran, name war No.
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Margaret A. Boegner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1886

8. AGE: Years	Months	Days	If less than one day
58	4	13	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Machinist at
11. Industry or business Continental Can Co

FATHER
12. Name Kasper John Boegner
13. Birthplace Germany

MOTHER
14. Maiden Name Magdalina Meninger
15. Birthplace Germany

16 (a) Informant Mrs Margaret A. Boegner
(b) Address 1205 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4439 Belair Rd.

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) (Date received by registrar) AUG 18 1944 Registrar Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1944 at 12 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Aug 16 1944 and that I last saw him alive on Aug 15 1944.

Immediate cause of death	Duration
Uremia	
Cardiac failure	
Due to Hypertensive-Cardio Vascular Renal disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 8-16-44

Branch #10

G20004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

183

Registered No. G20004

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Unknown White Male

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
41?			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory PUBLIC CEMETERY AUG 17 1944
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 18 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 7-8- 1944, at 9 A.M. P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7-8- at 4/1 P.M.
(b) Where did injury occur? Harbor, Light & W. Falls Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 7-12-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G20005

MARG. RESERVED FOR HEADING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton St.
(c) Hospital or institution: Ashburton Nursing Home 1512
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2596 Druid Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY SIEBERT

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife John A. Siebert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 4, 1864

8. AGE: Years 79 | Months 10 | Days 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Peter Edler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ricey (unknown)
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Rose M. Sanders
(b) Address 2596 Druid Park Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK CEM.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 18 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 15, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1944 to Aug. 15, 1944 and that I last saw h[e] alive on Aug. 15, 1944

Immediate cause of death: Myocardial Insufficiency — Duration: 1 wk
Due to: Arteriosclerosis — 7
Due to:
Other Conditions: Cystitis
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Sidney D. Levy
Address 2322 Eutaw Place Date signed 8/18/44

G20006 ✓ G20006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 721 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE OTTO (or Otto George) RUPPERSBERGER

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Kate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1874

8. AGE: Years 70 | Months 2 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Retired Butcher

11. Industry or business

FATHER 12. Name Lewis Ruppersberger

FATHER 13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary Quandtz

MOTHER 15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Kate Ruppersberger

(b) Address 721 E. Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (b)

(Date received by registrar) AUG 18 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1944 to 1944, and that I last saw h[illegible] alive on 1944

Immediate cause of death: Cardiac Insufficiency — Duration: ?

Due to: Arteriosclerosis Hypertension — Duration: ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Samuel Lowry

Address 1701 E North Ave Date signed 8/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

Registered No. G20007

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Aves
(c) Hospital or institution: Maryland General Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City, town, or location Baltimore #18 (If outside city or town limits, write RURAL and give town)
(d) Street No. 449 Marble Hall Rd (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kennard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 14 hr. 25 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name George Kennard
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Gladys Harkert
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Gladys Kennard
(b) Address 449 Marble Hall Rd

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 18-44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE ROAD

18 (a) Funeral director Lilly & Sons Inc.
(b) Address 403 S. WOLFE ST.

19 (a) AUG 18 1944 (Registrar) Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1944, at 4 40 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14-44 2 3 PM 1944, to 4 30 PM 8/16 1944, and that I last saw h alive on 4 39 P 1944.

Immediate cause of death: Bilateral Atelectasis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wilkins G. Mitchell M. D.
Address Md. Gen. Hosp. Date signed

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

W. - 89325 G20008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927 Registered No. G20008

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 323 S. Macon St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Steer

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-4239

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Sep.

6 (b) Name of husband or wife Sadie E. Werner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 8, 1861

8. AGE: Years 63 | Months 4 | Days 8 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business CROWN CORK SEAL CO.

FATHER
12. Name William Steer
13. Birthplace ?

MOTHER
14. Maiden Name Isabella Clark
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 19/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) Huntington Williams M.D. (Signature of local registrar)
(b) Date received AUG 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16- 1944 at 12.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1944 to 8-16 1944 and that I last saw him alive on 8-14 1944.

Immediate cause of death Terminal
arrhythmia -
Myocardial insuf
Due to Pulmonary edema
A.S.C.V.D.
Due to
Other Conditions Chron. Nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M. D.
Address B C H Date signed 8/17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82a G20009 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 GREENMOUNT AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 GREENMOUNT AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN H. FRENCH

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	215-18-9383

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife EMMA FRENCH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 25 1866

8. AGE: Years	Months	Days	If less than one day
77	7	23	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation CIGAR MAKER
11. Industry or business

FATHER
12. Name ALEXANDER FRENCH
13. Birthplace BALTO MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO. MD.

16 (a) Informant J. LEROY FRENCH (SON)
(b) Address 218 S. CASTLE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 21/44 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly & Justice Sons
(b) Address 403 S. HOLLINS ST.

19 (a) (Date rec'd by registrar) (b) Registrar
AUG 18 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 17 1944 at 8/30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944 to Aug 17 1944 and that I last saw him alive on Aug. 17 1944

Immediate cause of death	Duration
Cerebral Apoplexy	1 day
Due to Cerebral Sclerosis - & Hypertension	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Israel J. Feinglass
Address 500 N. Patterson Park Ave. Date signed 8/18/44

Israel J. Feinglass

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please w

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 F

G20010 G20010 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1102 S.LAKEWOOD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1102 S.LAKEWOOD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HOWARD E.FRAMPTON

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213 09 9603

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: MOLLIE FRAMPTON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN.4 1873

8. AGE: Years 71 | Months 7 | Days 11 | If less than one day ..hr. ..min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation JEWERLER

11. Industry or business JENKINS & CO.

FATHER
12. Name CHARLES W.FRAMPTON
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name CHAROLETTE BUCHER
15. Birthplace BALTO.MD.

16 (a) Informant MOLLIE FRAMPTON (WIFE)
(b) Address 1102 S.LAKEWOOD AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG.18/44 (month) (day) (year)
(c) Cemetery or crematory MT.CARMEL
Location ODONNELL ST.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.WOLFE ST.

19 (a) (Date received by registrar) AUG 16 1944 (b) Registrar Huntington Williams, M.D.

VS 10

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 15 1944, at 7 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12 1944, to Aug.15 1944, and that I last saw h im alive on Aug. 12 1944.

Immediate cause of death: Carcinoma of the liver — Duration: ?
Due to Chronic valvular heart disease — ?
Due to Chronic nephritis — ?
Due to Arterio-sclerosis — ?

Other Conditions Myocardial insufficiency — 2 days
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. B. Bronushas, M.D.
Address 3037 O'Donnell St. Date signed 8-15-4 M. D.

G20011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121R

G20011 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2537 Arunah Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2537 Arunah Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Adams,

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-6478

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel D. Adams,
6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) October 29. 1887

8. AGE: Years	Months	Days	If less than one day
56	9	18	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Embrodiary

FATHER
12. Name Cadmas Adams,
13. Birthplace Maryland

MOTHER
14. Maiden Name Fannie Walker,
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Ethel D. Adams,
(b) Address 2537 Arunah Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19. 1944 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Howard Co. Md.

18 (a) Funeral director George W. Little,
(b) Address 2700 Edmondson Ave.

19 (a) AUG 18 1944 (Date rec'd by registrar) Huntington W. Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 17 1944, at 11:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 5 1936, to August 17 1944, and that I last saw h[illegible] alive on August 17 1944

Immediate cause of death	Duration
Chronic Paren chymatous Nephritis	2 mo
Due to Organic Heart Disease	8 yr
Due to Hypertrophic arterio	8 yr
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chester Roland, M. D.
Address 8-17-44 Date signed
2032 Edmondson Ave.

VS 150

G20012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G20012
Registered No.

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 15-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 McKean Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Seidmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife David

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 3, 1899

8. AGE: Years	Months	Days	If less than one day
44	10	14	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Wife

FATHER
12. Name Harold Cohen
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah ?
15. Birthplace Russia

16 (a) Informant David Seidman
(b) Address 1645 Mc kean Ave

17 (a) Burial (b) Date thereof Aug, 18, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cem
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1126 W North Ave

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

AUG 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1944 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1944 to 8/17 1944, and that I last saw h. alive on 8/16 1944.

Immediate cause of death CARCINOMA STOMACH — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Steinberg
Address Sinai Hospital Date signed 8/17/44

STEINBERG

G20013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G20013

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1817 Lanvale Ave
(b) Street address Balto, Md
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hr
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Lanvale Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Eggs

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1944

8. AGE: Years | Months | Days | If less than one day hr. 10 min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Daniel Stephen Eggs
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Marian Moore
15. Birthplace Balto Md

16 (a) Informant Mrs. Marion Eggs
(b) Address 1817 Lanvale Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 18 1944 (Date rec'd by registrar) (d) Huntington Hillsinger M.D. Registrar

VS 380

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1944 at 1:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Aug 14 1944 and that I last saw h. alive on Aug 14 1944.

Immediate cause of death Prematurity Birth

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Perkins M.D.

Address 426 N. Gilmor St Date signed 8/17/44

G20014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registration No. G20014

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1214½ Penna. Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/44

8. AGE: Years	Months	Days	If less than one day
1 day			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Premature infant

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Eunice Young
15. Birthplace

16 (a) Informant Eunice Young
(b) Address 1214½ Penna. Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 18 1944 (Date filed by registrar) (b) Harry J. Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11/44 19 , at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4/44 19 to 8/11/44 19 , and that I last saw him alive on 8/10/44 19 .

Immediate cause of death Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dan Pascal, M.D.
Address University Hospital Date signed 8/11/44

G20015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G20015

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d. 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 N. Strieker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Mitchell

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	Negro	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 3o 1944

8. AGE: Years	Months	Days	If less than one day
→		9	hr. min.

9. Birthplace Baltimore City, Md.
(Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Carter
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Lewis
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address
19 AUG 18 1944 (Date rec'd by registrar) (c) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-9 1944, at 4 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1944, to 8-9 1944, and that I last saw her alive on 8-9 1944.

Immediate cause of death Resp. failure — Duration

Due to Prematurity - lack of development.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward Palmer M.D.
Address Univ. Hospital Date signed 8-9-44

G20016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G20016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Information as to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: Union Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Born in Hospital
(If outside city or town limits, write RURAL and give town)
(d) Street No. # 1710 Harkem Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Baby Boy Carter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: M.
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7/10/44

8. AGE: Years | Months | Days: 21 | If less than one day: ..... hr. ..... min.

9. Birthplace ..... (Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Rudolph Carter
13. Birthplace .....

MOTHER
14. Maiden Name Louise Young
15. Birthplace Va

16 (a) Informant Louise Carter
(b) Address .....

17 (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (month) (day) (year)
(c) Cemetery or crematory .....
Location PUBLIC CEMETERY AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address .....

19 AUG 18 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-1 1944, at 9.50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-21 1944, to 8-1 1944, and that I last saw him alive on 8-1 1944.

Immediate cause of death Resp. collapse — Duration .....

Due to Prematurity — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Edward Palmason, M. D.
Address Univ. Hospital Date signed 8-3-44

G20017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20017 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2805 Walbrook Ave - 16
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Darrell Funderburke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1, 1944

8. AGE: Years	Months	Days	If less than one day
		10 day	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name Thomas F. Leahey
13. Birthplace Pittsburgh Pa

MOTHER
14. Maiden Name Mary A. Funderburke
15. Birthplace Clover, S. C.

16 (a) Informant Mother
(b) Address 2805 Walbrook Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 18 1944 (Date rec'd by registrar) (Signature) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1944, at 7:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944, to Aug 11 1944, and that I last saw h alive on Aug 10 1944.

Immediate cause of death	Prematurity	Duration
Due to		
Due to		
Other Conditions	Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Winfred K Konigsberg M. D.
Address 1211 Eutaw Place Date signed

G20018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20018
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Argyle Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Malvina Perkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-26-44

8. AGE: Years | Months | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John E. Perkins
13. Birthplace Michigan

MOTHER 14. Maiden Name Gladys Stilwell
15. Birthplace Virginia

16 (a) Informant Malvina Clark
(b) Address 1007 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave

19 (a) AUG 18 1944 (Date rec'd by registrar) Registered by [illegible] Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute ulcerative pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed August 17 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20019 ✓ G20019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 Argyle Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 argyle ave (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Pitts

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife Jeffrson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Essex Co. Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name James Bailey
13. Birthplace Essex Co. Va.

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Nancy Pitts
(b) Address 1120 Argyle Ave Balto

17 (a) Burial (b) Date thereof Aug. 19-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Belair Road

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (b) Registrar
(Date received by registrar)
AUG 18 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16 1944, at 930A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1944 to 8/16 1944 and that I last saw h.. alive on 8/14 1944.

Immediate cause of death Cerebral Hemorrhage

Due to Hypertension.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Reynold Brightstone M. D.
Address 212 Druid Hill Ave Date signed 8/16/44

G20020

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

G20020
Registered No.

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanford, Rd.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 day
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 Cary St (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Walker Jerome Brown

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1938

8. AGE: Years	Months	Days	If less than one day
6		28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation child
11. Industry or business —

FATHER
12. Name Wm. K. Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Ethel Smith
15. Birthplace N. C.

16 (a) Informant Ethel Brown, Mother
(b) Address 420 Cary St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/16/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 18 1944 Huntington Williams, M.R.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/15 1944, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1944, to 8/15 1944, and that I last saw h[illegible] alive on 8/15 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Bulbar Poliomyelitis	2-3 d.
Due to	
Other Conditions Pharyngeal Paralysis	

(Include pregnancy within 3 months of death)
Date of operation 8/15/44 Tracheotomy
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Date signed 8-17

G20021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G20021
Registered No.

to #39414

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 791 W. Mulberry St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Maggie Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 67 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Jesse Jordan
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Charlotte ?
15. Birthplace: Maryland

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 19, 1944 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location

18 (a) Funeral director: Mrs. Katie R. Williams
(b) Address: 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M. D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16, 1944, at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15- 1944 to Aug. 16 1944 and that I last saw h er alive on Aug. 16 1944

Immediate cause of death: Cardiac failure due to hypertensive cardio

Due to: vascular disease

Due to: Acidosis - due to diabetes

Other Conditions: Diabetic gangrene of left foot

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy:

Duration
?
?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury —

23. Signature: S. P. Absano M. D.
Address: Balto. City Hosp. Date signed 8-17-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

G20022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48

G20022 Registered No. 3498

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 16
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Harlem Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Snowden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Divorced

6 (b) Name of husband or wife Wm. Brooks

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct 21 1900

8. AGE: Years	Months	Days	If less than one day
43	10	23	hr. min.

9. Birthplace Annearundel Co. Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business Day worker

FATHER
12. Name Levi Snowden
13. Birthplace Annearundel Co. Md

MOTHER
14. Maiden Name Nancy Shorter
15. Birthplace Annearundel Co. Md

16 (a) Informant Viola Broddick
(b) Address 1715 Harlem Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/18/1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) Filed AUG 18 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-14 1944, at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 19 44 to 8-14 19 44 and that I last saw her alive on 8-14 19 44.

Immediate cause of death
Carcinoma uteri

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration
Unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Strieker St Date signed 8-18-44

G20023 ✓ G20023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 1111 W. Fremont Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Baltimore, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/14/44

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alvin Smith
13. Birthplace Md

MOTHER
14. Maiden Name Edna Smith
15. Birthplace Balto Md

16 (a) Informant Martha Cough - Mother
(b) Address 1111 W Fremont Ave

17 (a) Buried (b) Date thereof 8-18-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Filed by Registrar) (b) Huntington Williams, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Aug 15 1944, and that I last saw h. alive on Aug 15 1944.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl V. Bayard, M. D.
Address Provident Hospital Date signed 8/16/44

G20024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G20024

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1322 N. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	4		hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lennon J. Brown
13. Birthplace Va.

MOTHER
14. Maiden Name Gertrude Dillard
15. Birthplace Balto. Md.

16 (a) Informant Gertrude Brown
(b) Address 1322 N. Chester St.

17 (a) Burial (b) Date thereof Aug. 18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location E. Donnell St.

18 (a) Funeral director John F. Milton
(b) Address 253 S. Jefferson St.

19 (a) (b) Huntington Williams M.D.
Registrar

AUG 16 1944

VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17/1944, at 1:20 A M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/16/1944 to 8/17/1944 and that I last saw h.e. alive on 8/17/1944.

Immediate cause of death Pulmonary edema

Due to Bronchopneumonia?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Murray Levin M. D.

Address Date signed

G20025 ✓ G20025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 637 Wyeth st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 Wyeth st (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Howard Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 218-18-0263

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Ida V. Howard
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5/23/1869

8. AGE: Years	Months	Days	If less than one day
75	2	23	hr. min.

9. Birthplace Unknown.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business
FATHER 12. Name John Howard.
13. Birthplace Unknown.
MOTHER 14. Maiden Name Unknown
15. Birthplace "
16 (a) Informant William Howard Jr.
(b) Address 2301 Harford Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Location Govans Rd & Harford Rd.
18 (a) Funeral director Ambrose Sac
(b) Address 414 N. Franklintown Rd.
19 (a) (Date rec'd by registrar) AUG 18 1944 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1944, at 7P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944, to Aug 16, 1944 and that I last saw h. alive on Aug 16 1944.

Immediate cause of death Hemorrhage Cerebral Accident — Duration 2 days
Due to Cerebral Hemmorrhage
Due to
Other Conditions Generalized arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul Leibfried
Address 1911 Ashwell Date signed M. 8 D. 19

G20026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56a ✓

Registered No. G20026

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 9-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5das.
(e) Length of stay in Baltimore (yrs., mos., or days) 12 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 633 E. 33rd street
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME: MARGARET E. HARRIS

3 (b) If veteran, name war: ----

3 (c) Social Security Account No. 705-05-2565

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Harris

6 (c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Oct. 7, 1903

8. AGE: Years 40 | Months 10 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace: Cincinnati, Ohio (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business:

FATHER
12. Name: Henry E. Brueggeman
13. Birthplace: Ohio

MOTHER
14. Maiden Name: Ellen Sheridan
15. Birthplace: Ohio

16 (a) Informant: Mr. John Harris
(b) Address: 633 E. 33rd street

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory: St. Joseph's New Cemetery, Cincinnati, Ohio
Location

18 (a) Funeral director: Chas. J. Evans & Son
(b) Address: 116 N. Mt. Royal Ave

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

AUG 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 17 1944, at 7 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12- 1944 to 8-17- 1944, and that I last saw h[illegible] alive on 8-17 1944.

Immediate cause of death: Shock - post operative. — Duration: 5 days

Due to: Pain & ruptured ectopic pregnancy

Due to: with ruptured extensive organs

Other Conditions: opt (chocolate)

(Include pregnancy within 3 months of death)

Date of operation: 7th.

Major findings of operation: ruptured & chocolate cyst tubo-ovarian pregnancy

of autopsy: No.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: [illegible] M. D.
Address: Medical Arts Bldg. Date signed

G20027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

Registered No. G20027

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: City Morgue
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 140 N. Exeter Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH LEE LOWE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife George Lowe

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Atlanta Ga. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name ?

13. Birthplace

MOTHER — 14. Maiden Name ?

15. Birthplace

16 (a) Informant George Lowe

(b) Address City Jail (140 N. Exeter)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location A.A. Co., Md.

18 (a) Funeral director Charles R. Law

(b) Address 802 Madison Ave

19 (a) AUG 18 1944 (Date filed by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14, 1944, at 11:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Wounds, lacerated, neck,

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-13-44 at 7 P.M.

(b) Where did injury occur? 140 N. Exeter Street

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? no

(d) Means of injury cut with razor blades

23. Signature H. L. Williams M.D.
and Medical Examiner.

Date signed Aug 14, 1944

G20028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316

Registered No. G20028

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 Park Heights ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4613 Park Heights ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Abrams.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work.

FATHER
12. Name: Unknown
13. Birthplace: Russia

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Russia

16 (a) Informant: Mrs. D. Katz
(b) Address: 4409 Fernhill ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 18/44 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Herring Run
Location: Bowleys Lane

18 (a) Funeral director: Sol Levinson & Bro
(b) Address: 1124-26 W North ave

19 (a) (b) Huntington Williams M.D. Registrar

AUG 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 17 1944, at 10 50 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1944, to Aug 14 1944, and that I last saw h[illegible] alive on Aug 14 [illegible]

Immediate cause of death: Ch Nephritis
Acute Pulmonary Edema

Duration

Due to:

Due to: Ch Myocarditis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: A. H. Hornstein

Address: 733 Ampudth St Date signed: 8/18/44 M. D.

G20029

G20029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County C
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2214 Rosedale St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Ray Brodsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex m | 5. Color or race wh | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 30 44

8. AGE: Years | Months | Days 18 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Morris Brodsky
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Irene Fintrat
15. Birthplace Balto.

16 (a) Informant Irene Brodsky
(b) Address 2214 Rosedale St

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 18 44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew Ce
Location Washington Blvd

18 (a) Funeral director Jack Levin Inc
(b) Address 1409 E. Balto. St

19 (a) Date received AUG 18 1944 (year) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1944, at 11:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1944, to 8/17 1944, and that I last saw him alive on 8/17 1944.

Immediate cause of death Resp. failure — Duration

Due to Bronchopneumonia

Due to

Other Conditions furunculosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia, furunculosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Aronson M. D.
Address Sinai Hosp. Date signed 8/18/44

G20030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

147c

Registered No. G20030

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 6/9/44
Trans. from Marine Hosp. Since 6/9/44
(e) Length of stay in Baltimore (yrs., mos., or days) Detroit, Mich.

2. USUAL RESIDENCE OF DECEASED:
(a) State Michigan (b) County
(c) City or town Detroit
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1445 E. Philadelphia Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT HENRY YOUNG

3 (b) If veteran, name war -

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1920

8. AGE: Years 23 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Detroit, Michigan (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Merchant Marine

FATHER
12. Name Peter Young
13. Birthplace Springfield, Ohio

MOTHER
14. Maiden Name Leona King
15. Birthplace Detroit, Michigan

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/18/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Lee, Oder
(b) Address 4644 York Rd.

19 AUG 18 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Aug. 15, 1944, at 6:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 9, 19 44 to Aug. 15, 19 44, and that I last saw h. im alive on Aug. 15, 19 44.

Immediate cause of death 1. Bronchial adenocarcinoma left main bronchus with metastases to the left lung Roots and mediastinum; 2. Pulmonary abscesses left lung. — Duration: Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 6/13/44-Bronchoscopy with drainage & aspiration of bronchus [illegible] left; 7/12/44-Thoracotomy with exploration.

Findings: As above

of autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Baltimore, Md. - Fred. Albrecht
Address U.S.Marine Hospital Date signed 8/15/44

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the cause of death clearly and legibly. Physicians: please write the correct age is especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. B 20031

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos. or days) 6 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 Gough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Butta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 6 hrs | Months | Days | If less than one day 6 hrs. min.

9. Birthplace Md. (Town, County, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Salvatore Butta
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Rose Mazziatt
15. Birthplace Baltimore Md.

16 (a) Informant Salvatore Butta
(b) Address 3416 Gough St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18. 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Dendell & Hofford
(b) Address 312 S. Highland Ave

19 (a) AUG 18 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17- 1944, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17-1944, to 8-17-1944, and that I last saw her alive on 8-17- 1944.

Immediate cause of death

Atelectasis & Cerebral Hem. — Duration

Due to

Due to Premature Birth

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Caesarean Section

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Thos. Norton, Jr.

Address Bon Secours Hosp. Date signed 8/17/44

G20032 ✓ G20032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2821 Alameda Blvd (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mary E. Sturgeon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife James [illegible]
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1872

8. AGE: Years	Months	Days	If less than one day
71	11	11	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business

FATHER 12. Name John Gregory
13. Birthplace Maryland
MOTHER 14. Maiden Name Sara Cochran
15. Birthplace Maryland

16 (a) Informant James I. Sturgeon
(b) Address 2821 the Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-1944 (month) (day) (year)
(c) Cemetery or crematory Western Location Baltimore Md:

18 (a) Funeral director Flynn & Flannery
(b) Address 1476 Light St.

8 19 1944 (Date received by Registrar) Huntington Williams, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1944, at 1155 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/44 19.. to 8/16/44 19.., and that I last saw her alive on 8/16/44 19..

Immediate cause of death	Duration
Subarachnoid Hemorrhage	3 weeks
Due to Hypertensive C. V. Disease	20 years
Due to	
Other Conditions Bronchopneumonia	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address Franklin Square Hosp Date signed

VS 3

G20033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E G20033 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1519 E Monument St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1519 E Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Barrett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1865

8. AGE: Years	Months	Days	If less than one day
79	10	28	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Thomas Barrett
13. Birthplace Md

MOTHER
14. Maiden Name Susan Meteor
15. Birthplace Md.

16 (a) Informant Florence Wade
(b) Address 5196 Monument St

17 (a) Burial (b) Date thereof Aug 19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A. County Md

18 (a) Funeral director Mrs. Robert E. Elliott Sr.
(b) Address 1291 N. Carrollton Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 18 1944 Huntington Woods, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Aug 16 1944, and that I last saw h[illegible] alive on Aug 16 1944.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Due to Myocarditis	
Due to Jumpers Knee	
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert L. Lafrenz
Address 522 N. Bond St Date signed 8/18/44 M. D.

G20034 ✓ G20034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170c

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. Sollers Point Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Watson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1933

8. AGE: Years	Months	Days	If less than one day
10	7	17	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation School Boy
11. Industry or business

FATHER
12. Name Bonnie Watson
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Thornhill
15. Birthplace Va.

16 (a) Informant Bonnie Watson
(b) Address 130 Above Beach Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location A. A. County Md.

18 (a) Funeral director Jno. Robt. A. Elliott & Bro.
(b) Address 1129 N. Eutaw St. Baltimore, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1944 at 9 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8/16/44 8:48 A.M. $5.00
(b) Where did injury occur? Sollers Pt. Rd. 150' west of Bunker Hill, Balto. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Pedestrian struck by auto

23. Signature H. H. Wallansmeier M.D. (and Medical Examiner.)
Date signed 8-16-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 N. Caroline Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gregory Richard Raab
3 (b) If veteran, name war None
3 (c) Social Security Account No. 212-01-0619
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Mrs. Elizabeth Raab
6 (c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) March 18, 1899
8. AGE: Years 45 Months 4 Days 28 If less than one day: hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cement Worker
11. Industry or business Unemployed
FATHER 12. Name Peter Raab
FATHER 13. Birthplace Maryland
MOTHER 14. Maiden Name Amelia Bockmeyer
MOTHER 15. Birthplace Maryland
16 (a) Informant Mrs. Elizabeth Raab (Wife)
16 (b) Address 1801 N. Caroline Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19, 1944 (month) (day) (year)
17 (c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto: Md.
18 (a) Funeral director George J. Ruth, Inc.
18 (b) Address 1755 Harford Avenue
19 (a) (Date rec'd by registrar) (b) Registrar

VS 116 AUG 18 1944 Huntington Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1944, at 11:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12 1944 to Aug. 16 1944, and that I last saw him alive on Aug 16 1944
Immediate cause of death Cardio-Respiratory Failure
Due to Acute Heart Failure
Due to Hypertensive Cardio-Vascular Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address Union Memorial Hosp. Date signed 8-16-44

G20035 G20035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
Baltimore City, Maryland
(a) Street address 1720 Montpilier Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1720 Montpilier St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Elizabeth Busch

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Lawrence H. Busch

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Dec 5th, 1879

8. AGE: Years 64 | Months 8 | Days 12 | If less than one day ##### min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John J. Luber
13. Birthplace Washington D.C.

MOTHER
14. Maiden Name Catherine Krieger
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Lawrence H. Busch (Husband)
(b) Address 1720 Montpilier Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) AUG 18 1944 (b) Huntington Ave Baltimore, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17th, 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1930, to Aug 17 1944, and that I last saw h[illegible] alive on Aug 15 1944

Immediate cause of death

Duration

Heart 1 Hr
Myocardial Insufficiency 24 Hrs
Due to Arteriosclerosis 2 Yrs
Due to Diabetes Mellitus
Due to Pressure

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward J. Finnegan

Address 2858 Westfield Ave Date signed 8/17/44

G20038 ✓ G20038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution: St. Joseph's Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days

(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4205 Sanner Ave. (If rural give location)

(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Samuel Stallings Frank

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie M.Stallings

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-29-1884

8. AGE: Years	Months	Days	If less than one day
60	3	18	hr. min.

9. Birthplace Mayo, A.A.Co.Md. (Town, county, and state)

10. Usual Occupation Maintainance Dept.

11. Industry or business B&.O.Railroad Co.

FATHER 12. Name Samuel F.Stallings

13. Birthplace Mayo,A.A.Co.Md

MOTHER 14. Maiden Name Sallie Stallings

15. Birthplace Mayo,A.A.Co.Md.

16 (a) Informant Mrs. Carrie M.Stallings

(b) Address 4205 Sanner Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8,19-44 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cemetery

Location North Ave & Rose St

18 (a) Funeral director Albert L Nitsch

(b) Address 1606 N.Chester Street

19 (a) AUG 18 1944 (Date rec'd by registrar) Registrar

Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16-44. 19 , at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6-44 19 , to 8-16-44 19 , and that I last saw h im alive on 8-16-44 19 .

Immediate cause of death Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions Arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Frank L. Vannie

Address St. Joseph's Hosp. Date signed 8-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20038 Registered No.

G20038

CERTIFICATE OF DEATH 1150

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1035 W Barre (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary F Deitzel
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
F	W	

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 23rd 1941

8. AGE: Years	Months	Days	If less than one day
2	8	26	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business
FATHER 12. Name James Deitzel
13. Birthplace Md
MOTHER 14. Maiden Name Mildred Wingate
15. Birthplace Md
16 (a) Informant Hosp. Record.
(b) Address Redwood & Green Sts
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Road
18 (a) Funeral director John J Cowan & Son
(b) Address 901-03 Hollins St
19 (a) (Date rec'd by registrar) (b) Washington Blvd

VS 150 AUG 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1944 at 10 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1944 to 8-19 1944 and that I last saw h[illegible] alive on 8-19 1944
Immediate cause of death Anesthetic Death — Duration
~~Due to~~
Due to Ruptured duodenal ulcer
Other Conditions Hernia - Hypertrophied tonsils.
(Include pregnancy within 3 months of death)
Date of operation 8-14-44
Major findings of operation: Same as above
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frank M. Shipley M. D.
Address Univ. Hosp. Date signed 8-19-44

G20039 BALTIMORE CITY HEALTH DEPARTMENT G20039
CERTIFICATE OF DEATH 93c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 36 S Fremont Ave.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 36 S Fremont Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ... years

3 (a) FULL NAME Edward G. Monroe

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Febry 22, 1914

8. AGE: Years	Months	Days	If less than one day
30.	5	25	... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Attorney
11. Industry or business

FATHER
12. Name John Monroe
13. Birthplace Lithuania

MOTHER
14. Maiden Name Julia Ayuskievecz
15. Birthplace Lithuania

16 (a) Informant Mr John Monroe
(b) Address 36 S Fremont Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Road

18 (a) Funeral director John J Cowan Son
(b) Address 2602 Gallows Street

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

AUG 18 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1944, at 6:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 8 1944 to 8/16 1944 and that I last saw him alive on 8/16 1944.

Immediate cause of death	Duration
Acute Cardiac Failure	1 da
Due to Rheumatic Cardiac Vascular Disease	8 Mos
Due to ...	
Other Conditions ...	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ...
Of autopsy ...

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ...
(b) Date of occurrence ...
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury ...
23. Signature Joseph H Lawrence M.D.
Address 1301 Washington Blvd Date signed 8/17/44

MARG... RESERVED FOR E...DING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63B

620040

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3405 Greenway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Greenway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nettie Jenkins Gomwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: M. John S. Gomwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21, 1872

8. AGE: Years 72 | Months 2 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Alfred Jenkins
13. Birthplace Balto. Md

MOTHER: 14. Maiden Name Hannah Roper
15. Birthplace Balto, Md

16 (a) Informant Hannah R. Gomwell
(b) Address 3405 Greenway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md.

18 (a) Funeral director Henry Jenkins & Sons
(b) Address Baltimore, Md

19 (a) AUG 18 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1944, at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1944, to Aug 17 1944, and that I last saw h[illegible] alive on Aug 17 1944.

Immediate cause of death Congestive Heart Failure — Duration: Years or days

Due to Rheumatic and Arteriosclerotic Heart Disease — Years

Due to

Other Conditions Thyrotoxicosis Senility & Emaciation — 1-2 yrs.
(Including pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert W. Garis
Address 1014 St. Paul St. Date signed M 8 D 18 44

G20049 HARRISON ✓ G20049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

300

Registered No.

MARYLAND RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 144 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Govanstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rolling Hasell Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mrs. Rolling H. Harrison

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 29, 1876

8. AGE: Years	Months	Days	If less than one day
68	6	18	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles K. Harrison
13. Birthplace Louisiana

MOTHER
14. Maiden Name Louise Hasell
15. Birthplace Va.

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (b) Date thereof Aug 20 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest Md.

18 (a) Funeral director Henry N. Jenkins & Sons
(b) Address McCulloh Eutaw and Lt.

19 (a) AUG 20 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1944, at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 29 1944, to Aug 17 1944, and that I last saw him alive on Aug 17 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Tabes Dorsalis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Hall M. D.
Address Union Memorial Hosp Date signed 8/17/44

G20042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G20042

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.d.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emil C. Buehrl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years 45 Months Days If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Balto. Nat.

Location UNIVERSITY MEDICAL SCHOOL AUG 19 1944

18 (a) Funeral director Commissioner of Health

(b) Address A. Lee Ocker 8/17/44

19 AUG 17 1944 (c) Huntington Williams Registrar

(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1944, at 9.42 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed August 5, 1944

2090

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20043

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

937

G20043
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3003 Elm Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Elm Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice AMANDA Gosnell

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widow
6 (b) Name of husband or wife Arthur F. Gosnell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 10, 1870
8. AGE: Years 74 Months 2 Days 7 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Napoleon Harding
13. Birthplace Md.

MOTHER
14. Maiden Name Dorsey
15. Birthplace Md

16 (a) Informant Mrs Naomi Bely
(b) Address 3660 Keswick Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-19-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Md.
18 (a) Funeral director Burge Funeral Home
(b) Address 3631 Falls Rd.
19 (a) (Date received by registrar) AUG 18 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1944, at 9:30 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry J. Pollenberg M.D. Medical Examiner.
Date signed August 18, 1944
per Robert Lee Graham M.D.

G20044

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20044

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da
(e) Length of stay in Baltimore (yrs., mos., or days) 2da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt
(c) City or town Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. Eastern Ave Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 14 44

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace W. B. D. H.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Edward Carroll
13. Birthplace Ann Arundel Co. Md.

MOTHER 14. Maiden Name Wildelmina Filpain Frank
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 18 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

2091

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 16 1944, at 1 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944, to Aug 16 1944, and that I last saw him alive on Aug 14 1944

Immediate cause of death Pneumonia Due to Pulmonary Atelectasis

	Duration
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rueben Bullerman

Address West Baltimore St. Md. Date signed 8-16-44 M. D.

G20045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G20045

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1212 Union Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas H. Kilmon

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Julia Kilmon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 7th. 1856

8. AGE: Years	Months	Days	If less than one day
88	-	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Mill Hand

FATHER — 12. Name Thomas H. Kilmon
FATHER — 13. Birthplace Md.

MOTHER — 14. Maiden Name Unknown
MOTHER — 15. Birthplace Unknown

16 (a) Informant Charles L. Kilmon
(b) Address 306 W. 31st. St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Taylor Ave. Md

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615 & 17 Chestnut Ave

19 (a) Aug 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16th. 44 19 , at 12.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 19 44 to Aug 16 19 44. and that I last saw him alive on Aug 16 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. N. Patterson M. D.
Address 1324 Reisterstown Rd Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

CG20046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54a Registered No. CG20046

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Light St
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 Middleship Rd.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John W Loving

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	married

6 (b) Name of husband or wife Carrie Black

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug-29-1893

8. AGE: Years	Months	Days	If less than one day
50 57	11	18	hr. min.

9. Birthplace Va. (town, county, and state)
10. Usual Occupation Electrician
11. Industry or business Betty Steel Co

FATHER
12. Name Chas L. Loving
13. Birthplace Va

MOTHER
14. Maiden Name York
15. Birthplace "

16 (a) Informant Mrs. Carrie Loving
(b) Address 18 Middleship Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave & Rd

18 (a) Funeral director John F. Connelly
(b) Address 414 Eastern Ave

19 AUG 19 1944 (Date rec'd by registrar) at Interment for Williamsport Md Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 1944, at 12:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-17 1944 to 8-16 1944 and that I last saw h/m alive on 8-16 1944

Immediate cause of death Edema of Brain — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles F. MacDonald M.D.
Address 1913 Light St Date signed 8-16-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20047 ✓ CG20047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61 Registered No.

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3115 Chestnut Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Mable H. Downs

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow.

6 (b) Name of husband or wife James A. Downs. Jr.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 19, 1877

8. AGE: Years	Months	Days	If less than one day
67	3	29	hr. min.

9. Birthplace Pennsylvania. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name Charles B. King.
13. Birthplace Pennsylvania.

MOTHER
14. Maiden Name Mary Bowers.
15. Birthplace Pennsylvania.

16 (a) Informant James A. Downs. Jr.
(b) Address 3115 Chestnut Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21/44 (month) (day) (year)
(c) Cemetery or crematory New Freedom Pa
Location

18 (a) Funeral director Thomas B. Sowman
(b) Address 3615-17 Chestnut Ave

19 AUG 19 1944 (Date rec'd by registrar) (By) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/44 19..., at 9:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19/44 19..., to 8/18/44 19..., and that I last saw her alive on 8/18/44 19...

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Intero-selerotic C.V. Disease	
Due to	
Other Conditions 1) Diabetes Mellitus 2) abcess of Leg	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius Stueck
Address Franklin Square Hospital Date signed 8/18/44

VS 3

G20048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G20048

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Valley & Preston Sts.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Ruppel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1862

8. AGE: Years	Months	Days	If less than one day
82	1	4	hr. 50 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Ruppel
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances –
15. Birthplace Maryland

16 (a) Informant Louise Dietz
(b) Address 1718 McKean Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19th 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st

AUG 19 1944 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1944 at 12 50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1944 to Aug. 17 1944, and that I last saw h[illegible] alive on Aug. 16, 1944

Immediate cause of death	Duration
Pneumonia –	36 hrs
Due to Fracture surgical neck of left humerus	8 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 8 1944 M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No
(Specify type of place)
(e) Means of injury Fell to floor

23. Signature T. E. Hamburger M.D.
Address Mercy Hosp. Date signed 8/12/44

For M.R.L. Graham, by Thomas J. Weddell, M.D.

G20049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 ✓ Registered No. G20049

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Union Memorial Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Calvin Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME James Pawley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1864

8. AGE: Years	Months	Days	If less than one day
79	7	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Meat Dealer

FATHER — 12. Name Finley Pawley
13. Birthplace Md.

MOTHER — 14. Maiden Name Margaret Carnes
15. Birthplace Md.

16 (a) Informant Ida M. Pawley
(b) Address 415 Calvin Ave.

17 (a) Burial (b) Date thereof 8/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St

AUG 19 1944 (a) (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 16 1944 at 5:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, apoplexy

Due to Arterio sclerotic cardio-vascular disease

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert L. Grotz M.D.
Medical Examiner.

Date signed Aug. 16, 1944

G20050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

935 ✓

Registered No. G20050

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 W. 40th St
(c) Hospital or institution:
Home Sav Incurables 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2y. 5 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md – (b) County
(c) City or town Balto –
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 W 40TH ST.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jessie Somerville Norris-Lewis –

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Edwin Lewis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24 – 1866

8. AGE: Years 78 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md –
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name George Somerville Norris
13. Birthplace Balto – md –

MOTHER 14. Maiden Name Francis Loyall
15. Birthplace Balto – md –

16 (a) Informant Mrs. Wharton
(b) Address 200 W 40th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/20/44 (month) (day) (year)
(c) Cemetery or crematory St Thomas church
Location Cockeysville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1219 St Paul St.

AUG 19 1944 (Date rec'd by registrar) (b) Huntington Williamsport Md

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1944 at 1 30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/20 1942 to 8/17 1944, and that I last saw him alive on 8/17 1944.

	Duration
Immediate cause of death Bronchopneumonia	4 Days
Due to Hypertensive Cardio Vascular Disease	10 yrs
Due to Arteriosclerosis (Sen)	10 yrs.
Other Conditions Detached Retina (Rt)	2½ yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Hershberger M. D.
Address 214 Medical Arts Bldg Date signed 8/17/44

G20051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 943

G20051 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N.Glover St.
(c) Hospital or institution: 6-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N.Glover St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christina McCurdy

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Chas.W.McCurdy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.7,1873

8. AGE: Years 71 | Months 6 | Days 11 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Henry Borgmann
13. Birthplace Germany

MOTHER
14. Maiden Name Christina -----
15. Birthplace Germany

16 (a) Informant Mrs.Elizabeth Smith
(b) Address 222 NGlover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug.21/44 (month) (day) (year)
(c) Cemetery or crematory St.Matthews Cem.
Location Balto Md.

18 (a) Funeral director Philip Young Sons
(b) Address 2024 Orleans St.

19 (a) [illegible] (b) Huntington Maryland

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug.18/44 19 ..., at ... M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1943, to Aug 18 1944, and that I last saw h[illegible] alive on Aug 18 1944.

Immediate cause of death	Duration
Chr. Myocarditis Aug 10	1943
Circulat Hemorrhage Aug 18	1944
Due to Arterio-Sclerosis	1943
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. J. Buechman M. D.
Address 350 N Date signed Aug 29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MAR[illegible] RESERVED FOR [illegible]DING

G20052 ✓

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36 ✓

Registered No. G20052

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanford R.D.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs 2.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2327 Nelson Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Rufus Tucker ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1930

8. AGE: Years 14 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Schl

11. Industry or business —

FATHER 12. Name Rufus A. Tucker
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Father
(b) Address 2327 Nelson Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-44 (month) (day) (year)
(c) Cemetery or crematory Basil Chapel
Location Catonsville Md

18 (a) Funeral director Dansbeo F. Holland
(b) Address 1631 Druid Hill Ave.

AUG 19 1944 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1944, at 12:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1944, to 8/17 1944, and that I last saw h alive on 8/17 1944.

Immediate cause of death Respiratory Failure

Due to Bulbar Poliomyelitis

Due to

Other Conditions Pharyngeal Paralysis

(Include pregnancy within 3 months of death)

Date of operation 8/17/44

Major findings of operation: Tracheotomy

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M.D.
Address Sydenham Hosp. Date signed 8-19

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 G20053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registration No. G20053

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 932 N Bond Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 932 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mandy Winbush

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Widow

6 (b) Name of husband or wife Willie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1884

8. AGE: Years	Months	Days	If less than one day
60	6	2	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Mayho
13. Birthplace Va

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Solomon Pondexter
(b) Address 932 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A.A. County Md

18 (a) Funeral director Wm R.J. Elliott & Son
(b) Address 1129 N. Carolina St.

19 (a) (Date received by Registrar) (b) Registrar

AUG 19 1944
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1944, at 7-00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Aug 17 1944, and that I last saw him alive on Aug 16 1944.

Immediate cause of death	Duration
~~(a)~~ BILATERAL PULMONARY TUBERCULOSIS FAR ADVANCED CASEOPNEUMONIC	about 1 yr
Due to (b) TYPE	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Solomon R Julian
Address 434 E 23rd St Date signed 8/18/44

G20054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20054 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 300 Mt Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 300 MT Holly St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J. Langood,

3 (b) If veteran, name war World War I

3 (c) Social Security Account No. 337-07-6787

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel V. Langood
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) January 8, 1892

8. AGE: Years	Months	Days	If less than one day
52	7	10	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Maintance Clerk,
11. Industry or business Bendix Corp,

FATHER
12. Name John Langood.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margerte Woehrle,
15. Birthplace Germany

16 (a) Informant Mrs Ethel V. Langood,
(b) Address 300 Mt Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore National Cem.
Location Baltimore Md.

18 (a) Funeral director George W Little,
(b) Address 2700 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Registrar, M.D.

AUG 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 18 1944, at 5:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 16, 1944 to Aug. 18 1944 and that I last saw [illegible] alive on Aug 16 1944

Immediate cause of death Coronary Thrombosis — Duration ?

Due to

Due to

Other Conditions Hypertension — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. E. Wells

Address 4100 Edmondson Ave Date signed 8/18/44

G20055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

D-20055 Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2755 Rayner Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-6
(e) Length of stay in Baltimore (yrs., mos., or days) 38 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2755 Rayner Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara J. Hammett,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Martin L. Hammett,

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9. 1852

8. AGE: Years 91 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace Calvert Co. Md. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Abrham Bowen,
13. Birthplace Calvert Co. Md.

MOTHER
14. Maiden Name Frances Simons,
15. Birthplace Calvert Co. Md.

16 (a) Informant Mrs Clara C. Eastman,
(b) Address 2755 Rayner Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 19. 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location Baltimore Md.

18 (a) Funeral director Robert S. Little,
(b) Address 2700 Edmondson Ave.

19 (a) (Date received by registrar) 1944 Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG 17 1944, at 8.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to Aug 17 1944.
and that I last saw h[illegible] alive on Aug 17 1944.

Immediate cause of death Myocardial Insufficiency - Arteriosclerotic

Duration

Due to Hypertrophy & congestive failure 1 year

Due to Generalized arterio sclerosis 4 yrs

Other Conditions Chronic nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W W Michael M. D.

Address 2701 Edmondson Ave Date signed Aug 18 44

Huntington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20056

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93D

G20056 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 124 1/2 W. Read St
(a) Baltimore City, Maryland Baltimore, Maryland
(b) Street address
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 124 1/2 W. Read Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Lance

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Doming Wylie
13. Birthplace S.C.

MOTHER 14. Maiden Name Julia Blount
15. Birthplace S.C.

16 (a) Informant Mrs Mildred Layne
(b) Address 351 St Nicholas Pl. N.Y.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-19-1944 (month) (day) (year)

(c) Cemetery or crematory
Location Georgetown, S. Carolina

18 (a) Funeral director Mrs. Francis A. Hemsley
(b) Address 548 W. Biddle St

AUG 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1944 at 1:P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerosis
endocrinales
Due to disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed August 18 1944

G20057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20057 Registered No.

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GRACE LEE PFENNIG

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Daniel W., Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1872

8. AGE: Years	Months	Days	If less than one day
72	7	1	hr. min.

9. Birthplace Brookville, Montgomery Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Bolster
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Eliza League
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Daniel W. Pfennig Jr.
(b) Address 2020 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) AUG 19 1944 (Date received by Registrar) (b) Registrar

AUG 19 1944 Huntington Williams Jr.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17, 1944, at 5:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Aug 17 1944 and that I last saw h[illegible] alive on Aug 17 1944.

Immediate cause of death: Coronary Thrombosis — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry Ashman M.D.
Address 9W Madison Date signed 8/18/44 M. D.

G20058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G20058

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Green Spring & Belvedere Rd

(c) Hospital or institution: Hebrew Home for aged & Infirm 7-17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 yr 6 m 5 Days

(e) Length of stay in Baltimore (yrs., mos., or days) 34 yr 6 m 5 Days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3321 W. Rogers Ave (If rural give location)

(e) Citizen of foreign country? Yes (Yes or No)

If yes, name country Russia

3 (a) FULL NAME REBECCA ABRAMOWITZ

3 (b) If veteran, name war: non

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Gershon

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug-10-1858

8. AGE: Years 86 | Months 0 | Days 8 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Inmate - at Home

11. Industry or business Home for aged

FATHER

12. Name Jehuda Bogdonofsky

13. Birthplace Russia

MOTHER

14. Maiden Name Gittel ?

15. Birthplace Russia

16 (a) Informant Bessie Patashnick

(b) Address 3321 W Rogers Ave Baltimore

17 (a) BURIAL & REMOVAL (Burial, cremation, or removal) (b) Date thereof 8-20-44 (month) (day) (year)

(c) Cemetery or crematory MOUNT JUDAH CEMETERY

Location CYPRESS HILLS, N.Y.

18 (a) Funeral director Jack Levin Inc.

(b) Address 1437 E. Baltimore St.

19 (a) (Clerk registering return) (b) Chas. Wallace Waesche, M.D. Registrar

AUG 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-18-44 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-13 1941, to 8-18 1944, and that I last saw h[er] alive on 8-18 1944.

Immediate cause of death	Duration
Ch. card. vas. disease	
Arteriosclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edmund Levin M. D.

Address Levindale Date signed 8/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G20059
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 931 W Franklin St
(c) Hospital or institution: 18-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 931 W. Franklin S
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Lattimore

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Devilla

6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): 10/24/1881

8. AGE: Years: 62 | Months: 9 | Days: 20 | If less than one day: hr. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Robt. Lattimore
13. Birthplace: Va.

MOTHER
14. Maiden Name: Sarah Gregory
15. Birthplace: Va

16 (a) Informant: Devilla Lattimore
(b) Address: 931 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 8/20/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn Cem.
Location: Balto. Md

18 (a) Funeral director: Charles G. Cooper.
(b) Address: 512 N. Carrollton Ave.

19 (a) Filed (b) Registrar
AUG 19 1944
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/14/44 19 , at 5:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 19 44 to 8/14 19 44 and that I last saw h alive on 8/13/44

Immediate cause of death

Due to Cerebral Hemorrhage 2 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Cullcome M. D.

Address 1131 Harlem Ave Date signed 8/19/44

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20060 Funeral Home

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G20060

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/17/44
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State S.Carolina (b) County
(c) City or town Columbia (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Maryland Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph DAVID EASLER, JR.

3 (b) If veteran, name war -
3 (c) Social Security Account No. 248-30-7923

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife -
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 21, 1927
8. AGE: Years 17 | Months 2 | Days 28 | If less than one day ... hr. ... min.
9. Birthplace Eagle Pass, Texas (Town, county, and state)
10. Usual Occupation AS Trainee
11. Industry or business Merchant Marine

FATHER: 12. Name Joseph David Easler
13. Birthplace Columbia, S.C.

MOTHER: 14. Maiden Name Della Viola Brassell
15. Birthplace Columbia, S.C.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 - 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Columbia S. Carolina

18 (a) Funeral director Pott & B.M. Walter
(b) Address Pratt & Stricker Sts

19 (a) (b) Huntington Williams, M.D. Registrar

AUG 19 1944

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH August 18, 1944, at 1:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17, 1944 to Aug. 18, 1944 and that I last saw him alive on Aug. 18, 1944

Immediate cause of death: Dislocation of cervical vertebrae C-4 with transection of cord
Due to
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 4-1 (Morris
(b) Date of occurrence Aug. 16, 44 ? M
(c) Where did injury occur? Baltimore Off ship-presumably in harbor. (City or town) (County) (State)
PRATT & GAY
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work? No
(e) Means of injury Dived & struck another man's head or shoulders beneath him.
23. Signature Wm M Crawford M. D.
Address Balto., Md. Date signed 8/17/44

Approved: Robert Lee Preston M.D. 8/18/44

G20061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20061

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1909 Brunt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1909 Brunt St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Braxton

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Wm. Braxton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-10-94

8. AGE: Years 50 | Months 4 | Days — | If less than one day hr. min.

9. Birthplace Alexandria, Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Unknown

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Henry Robinson

(b) Address 1909 Brunt St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/19/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Watson

(b) Address 1000 Pleasant Ave

19 (a) AUG 19 1944 (Date received by local registrar) (b) Huntingtown Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-15- 1944 at 9:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15- 1944 to 8-15- 1944 and that I last saw h— alive on — 19—.

Immediate cause of death: Hypertensive Heart Disease — Duration: 18 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Rose M. D.

Address 1516 N. Monroe St. Date signed 8-19-44

Approved: Henry L. Wollenweber M.D. per Robert Lee Graham M.D.

G20062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20062 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1601 Asquith St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Battery Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph A. Brannan
3 (b) If veteran, name war —
3 (c) Social Security Account No. 215-09-0699
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 28-1884
8. AGE: Years 60 Months 4 Days 20 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Michael T. Brannan Sr.
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Mc Henney
15. Birthplace New York

16 (a) Informant Michael T. Brannan Jr.
(b) Address 1601 Asquith St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.
18 (a) Funeral director Flynn & Flynn
(b) Address 1116 Light St.
AUG 19 1944 Huntington Williams MD
(Date received by Registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 17 1944 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1937 to Aug 17, 1944 and that I last saw h~~er~~ alive on Aug. 17, 1944.

Immediate cause of death: Cerebral Thrombosis — Duration 10-9-37
Left Side Hemiplegia
Due to: Chronic Myocarditis - Auricular
Due to: Fibrillation
Other Conditions: Cerebral Thrombosis. — 8-16-44
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Edward Norris M. D.
M. D.
Address 107 East Lexington St. Date signed Aug. 18, 1944

G20063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G20063 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (if outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Roy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 4 | Days | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: Willie Hamlin
15. Birthplace: Va.

MOTHER — 14. Maiden Name: Evelin Roy
15. Birthplace: Va.

16 (a) Informant: Father
(b) Address: 1428 Mosher.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion
Location: Relto. Co Md

18 (a) Funeral director: Chas F Alyard
(b) Address: 927 N. Mount st

AUG 19 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1944, at 1:34 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1944 to Aug 19 19 44, and that I last saw h/ alive on Aug 19 1944

Immediate cause of death	Duration
Melanlution	
Due to Acute Gastro-enteritis	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: H W Campbell M. D.
Address: Crondall Hospital Date signed: 8/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

B 20064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E

B 20064

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Any correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Bethlehem - Fairfield Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel R.F.D.
(c) City or town Rainer Heights, Linthicum
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hammond's Ferry Road, NR.
Nursery (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard H. Leach

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9199

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8-1908

8. AGE: Years	Months	Days	If less than one day
36	3	10	hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation Erector Leader
11. Industry or business Bethlehem Fairfield Shipyards

FATHER
12. Name Edward Garfield Leach
13. Birthplace York, Pa.

MOTHER
14. Maiden Name Lillie Brenneman
15. Birthplace York, Pa.

16 (a) Informant Mrs. Richard H. Leach
(b) Address Linthicum Hgts., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Anne Arundel Co., Md.

18 (a) Funeral director Thomas W. Singleton
(b) Address Glen Burnie, Maryland

19 (a) Received 1944 (Date received by registrar) (b) Registrar Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1944 at 3 30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of back — Multiple Fractures of ribs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25-6

(a) Date of injury August 18 1944 3 P. M.
(b) Where did injury occur? Bethlehem - Fairfield shipyards
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by steel plate

23. Signature Robert H. Graham M.D.
Medical Examiner.
Date signed Aug. 18, 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

45818 G20065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

460

G20065

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Oman
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 7 Oman W. Va
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alex Fedchenia

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-88

8. AGE: Years	Months	Days	If less than one day
56	1	2	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Paul Fedchenia
13. Birthplace Russia

MOTHER
14. Maiden Name Mary Kannozhevick
15. Birthplace Russia

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 19/1944
(month) (day) (year)
(c) Cemetery or crematory
Location Oman W. Va

18 (a) Funeral director John E. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 AUG 21 1944 (b) Huntington, West Virginia, Aug 19 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-17- 1944, at 8.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1944, to Aug-17 1944, and that I last saw him alive on Aug-17 1944.

Immediate cause of death	Duration
Thrombosis.	
Due to Hypertension.	
Due to (war)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or Town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Barlow Wright M. D.
Address Johns Hopkins Date signed 8-21-44

A3691 G20066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 L G20066

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Aberdeen
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry S. Deckman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-34

8. AGE: Years 9 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Harford Co., Md
(Town, county, and state)

10. Usual Occupation School boy

11. Industry or business

MOTHER / FATHER
12. Name Myrna Deckman
13. Birthplace Harford Co., (Md)
14. Maiden Name Lucy McCreary
15. Birthplace (Pa)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Aug 20 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dublin Cem
Location Harford Co Md

18 (a) Funeral director H. S. Bailey
(b) Address Darlington, Md

AUG 22 1944 (Date received by Registrar) Huntington Williamsport, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19- 1944 at 10 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1944 to 8-19- 1944 and that I last saw him alive on 8-19-1944

Immediate cause of death Tuberculous Meningitis — Duration 3 wks?

Due to

Due to

Other Conditions Pulmonary Tbc

(Include pregnancy within 3 months of death)

Date of operation Aug. 12

Major findings of operation: No abscess

of autopsy: Probable Tbc Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Jay Osgood M. D.

Address Johns Hopkins Hosp. Date signed Aug 19

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20067 G20067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Co.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Phila. + Ridge Roads
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Archibald M. Conklin

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
W	139-07-9212	male	White	married

6 (b) Name of husband or wife Ruth Conklin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26 1899

8. AGE: Years	Months	Days	If less than one day
50	3	22	hr. min.

9. Birthplace Springfield, Missouri
(Town, county, and state)
10. Usual Occupation Metal Worker
11. Industry or business Glenn L. Martin

FATHER
12. Name Edward Conklin
13. Birthplace Michigan

MOTHER
14. Maiden Name Maude Noe
15. Birthplace Arkansas

16 (a) Informant Mrs. Ruth Conklin Wife
(b) Address Phila + Ridge Rds Balto

17 (a) Burial (b) Date thereof 8/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) AUG 20 1944 (b) Huntington Williams, M.D. Registrar
(Date shield by registrar)

VH 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/ 1944, at 10:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/26 1944, to 8/18 1944, and that I last saw him alive on 8/18 1944.

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Myocardial infarction	
Due to Arterio sclerotic h. dis.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Myocardial infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Aronson M. D.
Address Sinai Hosp. Date signed 8/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Duplicate

G20068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1943

G20068

Registered No. ..... yr.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1400 N. Caroline St.

(c) Hospital or institution:

St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days

(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County .....

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1044 W. Franklin St.

(If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Bennett Tyson Elder

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 717-07-8919

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary S. Elder

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 2nd 1870

8. AGE: Years 73 | Months 9 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Emmittsburg Md.

(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Pa. R. R.

FATHER 12. Name Thomas Elder

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Md.

16 (a) Informant Mary S. Elder

(b) Address 1044 W. Franklin St.

17. Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)

(c) Cemetery or crematory Emmittsburg

Location Emmittsburg Md

18 (a) Funeral director Fallon & Forker

(b) Address 1217 E. Lexington St. Funeral Home, Md.

19 (a) ..... (Date received by registrar) (b) ..... Registrar

VS-150

AUG 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1944, at 3:20 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15- 1944 to 8-17 1944, and that I last saw him alive on 8-17- 1944

Immediate cause of death: Cerebral Embolism

Due to: Cardiac Disease

Due to: .....

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? .....

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....

(Specify type of place)

(e) Means of injury .....

23. Signature Evelyn J. Ensworth M.D.

Address 1044 W. Franklin St. Date signed 8/17/44

MARK "RESERVED FOR READING" OR "RESERVED FOR REGISTRAR". Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

G20069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20069 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Every correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days) 3d

2. USUAL RESIDENCE OF DECEASED: Queen Anne
(a) State Md (b) County Kent
(c) City or town Stevensville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Medford Clendaniel

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/1935

8. AGE: Years	Months	Days	If less than one day
9	6	25	hr. min.

9. Birthplace Stevensville, Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Donald M Clendaniel
13. Birthplace Md

MOTHER
14. Maiden Name Nellie Stallings
15. Birthplace Md

16 (a) Informant Mr Thomas
(b) Address Stevensville Md

17 (a) Removal (b) Date thereof 8/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Stevensville
Location Stevensville Md

18 (a) Funeral director Wilborn Funeral Home
(b) Address 1219 E Pratt St

19 (a) (Data to be filled in by registrar) (b) Huntington Williams, M.D. Registrar

AUG 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19/44 19 , at 1 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16/44 to 8/19 1944, and that I last saw h im alive on 8/19 1944.

Immediate cause of death Pneumonia
Post operative
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Herniaplasty
Major findings of operations: Inguinal Hernia
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J R Leuthen M. D.
Address McCready Hosp Date signed 8/19/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a G20070
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert St
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED
(a) State District of Columbia (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Penna. Ave. N.W. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME George Lewis Vance
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mrs. Julia Vance
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) June 14, 1883

8. AGE: Years 61 | Months 2 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Pennsylvania (Town, county and state)

10. Usual Occupation Tester — Internal Revenue
11. Industry or business

FATHER
12. Name Geo. Washington Vance
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Ingham
15. Birthplace Pa.

16 (a) Informant Mrs. Julia Zimmerman Vance
(b) Address 2115 Penna. Ave. N.W. Wash. D.C.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Aug. 20, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Washington, D.C.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) AUG 20 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1944, at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1944, to Aug 19 1944, and that I last saw him alive on Aug 19 1944.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Coronary Thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elmer P. Brown M. D.
Address U.M.H. Date signed 8-19-44

G20071 — BALTIMORE CITY HEALTH DEPARTMENT — G20071

CERTIFICATE OF DEATH #62

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22d
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (17) (If outside city or town limits, write RURAL and name town)
(d) Street No. 150 Wilson Court (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Bertha Adle McDonald

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife John F. McDonald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 24, 1887

8. AGE: Years	Months	Days	If less than one day
57	5	28	hr. min.

9. Birthplace Illinois (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Oscar Adle
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Adams
15. Birthplace Germany

16 (a) Informant Son Mr. Chas. Stinchcomb
(b) Address 150 Wilson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eastern Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. (Registrar)

AUG 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 August 1944 at 8:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 18 July 1944 to 19 Aug 1944 and that I last saw h. he alive on 19 Aug 1944

Immediate cause of death	Duration
Cardiorespir. failure	
Due to Metastatic Carcinoma of Sigmoid	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 16 Dec 1943

Major findings of operation: Ca Sigmoid attach'd to ovary, Metastases of Liver

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Mungaturza Jr. M. D.
Address 322 E. University Pkwy Date signed 8/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARRIED—NOT RESERVED—FOR BINDING

G20072 BALTIMORE CITY HEALTH DEPARTMENT X G20072
CERTIFICATE OF DEATH 1944 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Howard Sts.
(c) Hospital or institution: University Hospital 4-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Baltimore St. E.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Koval, John

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.
M	W	

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known ?

8. AGE: Years	Months	Days	If less than one day
58?			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Cedar Koval
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant Mrs. Mary Koval
(b) Address a.a. County Md.

17 (a) Burial (b) Date thereof Aug. 21-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russian
Location Stoney Run, Arundel Anne Co.

18 (a) Funeral director John A. Grebianckas Jr.
(b) Address 423 S. Paca St.

19 (a) AUG 20 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 14, 1944, to August 17, 1944, and that I last saw h.i.m. alive on August 16, 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Chronic Myeloid Leukemia	3 yrs.
Due to Cardiac Failure	3 mos.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Dean Paschal, M.D.
Address University Hosp. Date signed 8/17/44

G20073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G20073
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 5/4/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 5/4/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 S. Lowell Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MABELLE ROGERS (MRS.)

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1886

8. AGE: Years 58 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Washington, Maine
(Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business Public Health Service

FATHER
12. Name Elisha Linscott
13. Birthplace Damascotta, Maine

MOTHER
14. Maiden Name Elizabeth Johnson
15. Birthplace Arlington, Va.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/44 (month) (day) (year)

(c) Cemetery or crematory
Location Framingham, Mass.

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Road

19 (a) AUG 20 1944 (Date received by registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 4, 1944, to Aug. 18, 1944, and that I last saw him alive on Aug. 18, 1944.

Immediate cause of death: Perforation of the colon through the carcinoma at the Unk. splenic flexure with generalized advanced peritonitis — Duration: Unk.

Due to: Carcinoma of the splenic flexure of the colon with metastases in the regional lumphnodes, spleen, and liver — 1 yr.

Other conditions:
(Include pregnancy within 3 months of death)

Date of operation: thoracentesis-6/7, 8/3, 8/7, 8/11/44 Diag.dilatation & curettage.

Major findings of operation: Cystic mass in region left ovary. Pleural effusion, left.

Date of autopsy:

PHYSICIAN: cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Williams M. D.
Address Baltimore, Md. Date signed 8/19/44

PHS-52807

G20074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20074

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 Bruce St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Rice
13. Birthplace Virginia,

MOTHER
14. Maiden Name Ben. Anna
15. Birthplace Calvert Co Md

16 (a) Informant Alexander Rice
(b) Address 937 N. Bruce st

17 (a) Burial (b) Date thereof 8/22/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. H. Alexander
(b) Address 942 Huntington Ave.

19 (a) AUG 20 1944 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1944, at 7:50 A M

21. I certify that I took charge of the remains described above, held an Autopsy
Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.

Date signed August 19 1944

G20075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 a

G20075 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address N. Calvert St

(c) Hospital or institution: Mercy Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) 52 yr.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltcity

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1116 St. Paul. (If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country NO

3 (a) FULL NAME Fletcher Pentz (WILLIAM FLETCHER PENTZ, 3rd.)

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/19/1892

8. AGE: Years 52 | Months 5 | Days 29 | If less than one day: hr. min.

52

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Auto Mechanic

11. Industry or business Automobile Garage

FATHER

12. Name Wm. F. Pentz., M.D.

13. Birthplace Balto. Md.

MOTHER

14. Maiden Name Betty T. Hauck.

15. Birthplace Balto. Md.

16 (a) Informant Mr. Lesley Galloway

(b) Address 1116 St Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore, Md.

18 (a) Funeral director Stewart & Mowen Company

(b) Address 108 W. North Av. (W. F. Wooden-Suc.)

AUG 20 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1944 to 8/18 1944 and that I last saw him alive on 8/18 1944

Immediate cause of death Card.-Resp. failure.

Due to Gast. Hemor. Germinal Pneum

Due to Cere. Exp vgood, Accident

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2-3wks.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature M. Jane Foley M. D.

Address Mercy Hosp. Date signed 8/18/44

G20076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G20076 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 Hampnet Ave
(c) Hospital or institution: Gates Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 Hampnet Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F Gannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1883

8. AGE: Years	Months	Days	If less than one day
61	0	11	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation General Work
11. Industry or business Nursing Home

FATHER
12. Name Patrick Gannon
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Gates Nursing Home
(b) Address 1703 Hampnet Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L.J. Rush
(b) Address 4305 Northern Pkwy

19 (a) AUG 20 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1944, at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944, to Aug 19 1944, and that I last saw him alive on Aug 18 1944

Immediate cause of death	Duration
Pyelonephritis	2 yrs
Due to Glomerulonephritis	
Due to	
Other Conditions Uremia, Chronic myocarditis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. V. Harold
Address 4906 Harford Road Date signed 8/20/44

G20077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20077 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2622 Hudson Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2622 Hudson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME STANISLAWA IMBIEROWICZ

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Franciszek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/6/75

8. AGE: Years	Months	Days	If less than one day
68	10	11	hr. min.

9. Birthplace Poland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Anthony Chojnacki
13. Birthplace Poland

MOTHER
14. Maiden Name ------ Ratajczak
15. Birthplace Poland

16 (a) Informant Mrs. Mary Wasik
(b) Address 2622 Hudson Street

17 (a) Burial (b) Date thereof 8/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Mt. Carmel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1808 Eastern Avenue

19 (a) (b) Huntington Williams M.D.
(Signature of registrar)

AUG 20 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1944, at 3 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Aug 17 1944, and that I last saw h[illegible] alive on Aug 17 1944

Immediate cause of death Coronary Occlusion — Duration 8/16/44

Due to Chr. Endocarditis — 1/1/44

Due to Arteriosclerosis — 1938

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J Rymer M. D.
Address 801 N Kenwood Ave Date signed Aug 17/44

G20078 BALTIMORE CITY HEALTH DEPARTMENT G20078

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Whitelock st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JAKE KELLNER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	white	married

6 (b) Name of husband or wife Mary Kellner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12. 1887

8. AGE: Years	Months	Days	If less than one day
57	1	7	hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Bartender

11. Industry or business

FATHER 12. Name Isaac Kellner
13. Birthplace Poland

MOTHER 14. Maiden Name Hannah Kessler
15. Birthplace Poland

16 (a) Informant Morris Kessler
(b) Address 934 Whitelock st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 20/44 (month) (day) (year)
(c) Cemetery or crematory Helgus Mt Zion
Location German Hill Road

18 (a) Funeral director Sol Kevmont & Bro
(b) Address 1124-26 W North ave

19 AUG 20 1944 (Date of receipt by registrar) (b) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1944 at 10:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 1944, to Aug 19 1944 and that I last saw h. alive on Aug 19 1944.

Immediate cause of death Intestinal obstruction — Duration

Due to Mesenteric thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Danny J Taylor M. D.
Address WBGH Date signed 8/19/44

G20079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 3a

G20079 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 W North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 38yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 W North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isidor Katz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Nettie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business Tailor

FATHER
12. Name Teria Katz
13. Birthplace Russia

MOTHER
14. Maiden Name Freda ?
15. Birthplace Russia

16 (a) Informant Nettie Katz
(b) Address 719 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug, 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrews Friendship
Location 3600 E. Balto st

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) AUG 20 1944 (Date received by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION 9.15

20. DATE OF DEATH Aug 18 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944, to Aug 18 1944, and that I last saw h[illegible] alive on Aug 18 1944.

Immediate cause of death: Arteriosclerosis Cerebral hemorrhage — Duration: 10 Yrs 4 Days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H G Jones M. D.
Address 2818 Clifton Ave Date signed 8/19/44

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

G20080 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Park Heights Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mrs. Esther Mizen (MIZEN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Jacob Mizen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1882

8. AGE: Years 62 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Benjamin Bower
13. Birthplace Russia

MOTHER
14. Maiden Name Anna ?
15. Birthplace Russia

16 (a) Informant Mrs. Ann Tipnis
(b) Address 4015 Park Hgts Ave. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1139 E. Balto St

AUG 20 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1944, at 8:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1944 to Aug 20 1944 and that I last saw her alive on Aug 20 1944.

Immediate cause of death: Acute cardiac dilatation — Duration 14 hrs

Due to Nutritional deficiency — yrs

Due to

Other Conditions Prolapse of uterus — yrs.

(Include pregnancy within 3 months of death)

Date of operation Aug. 15. 1944

Major findings of operation: nothing

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glenn O. Frost M. D.
Address Union Memorial Hosp. Date signed 8-20-44

G20081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20081 Registered No. 1228

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 d
(e) Length of stay in Baltimore (yrs., mos., or days) 38 d

2. USUAL RESIDENCE OF DECEASED:
(a) State South Carolina (b) County
(c) City or town Dillon
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth FASS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Jewish | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife DAVID FASS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 JAN 1891

8. AGE: Years 53 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harry Herr
13. Birthplace Europe

MOTHER
14. Maiden Name Tobby
15. Birthplace Europe

16 (a) Informant Son, David Schwartz
(b) Address Dillon, So. Carolina

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-20-44 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom
Location Winders Mill Rd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St.

AUG 20 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 19 August 1944 at 1050 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 12 July 1944, to 19 Aug 1944, and that I last saw her alive on 19 Aug 1944

Immediate cause of death Cardio-respiratory failure — Duration

Due to

Due to (over)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Winegardner Jr. M.D.
Address 332 E. University Pkwy Date signed 8/19/44

G20082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G20082
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) died a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3534 E Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lengsfeld Lengsfeld

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 26-1939

8. AGE: Years	Months	Days	If less than one day
5	4	23	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Leo C Lengsfeld
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Richter
15. Birthplace Baltimore

16 (a) Informant Anna Lengsfeld
(b) Address 3534 E Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 200 E. Baltimore St.

AUG 20 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1944, at 11:15 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull.
Accident.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-18-44 at 10:50 A. M.
(b) Where did injury occur? N. Bound on Conkling & Edmondson Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by army truck.

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed August 18, 1944.

HELBING

G20083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH AHW

G20083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2327 E Fayette
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 67yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 2327 E Fayette
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Helbing

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-03-4923

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine Helbing
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 13. 1877

8. AGE: Years 67 | Months 3 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Fireman
11. Industry or business Salvage Corps

FATHER
12. Name John H Helbing
13. Birthplace Germany

MOTHER
14. Maiden Name Magdalena Windler
15. Birthplace Germany

16 (a) Informant Catherine Helbing
(b) Address 2327 E. Fayette

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Rural

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans

19. (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 15 Huntington, Hillcrest 1122

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1 1943. to Aug 18, 1944. and that I last saw h. alive on Aug 18, 1944.

Immediate cause of death	Duration
Myocardial Failure	Immediate
Due to Coronary Occlusion	1 year.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Frank M. Ogden M. D.
Address 2701 N. Calvert St Date signed Aug 22 44

MARRIAGE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20084

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310 Registered No. G20084

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1208 Eutaw Place
(c) Hospital or institution: Elmhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2115 Belair Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Elizabeth Durall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Spriggs Durall

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) May 5 1855

8. AGE: Years 89 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation

11. Industry or business at Home

FATHER 12. Name Chas A Gantz

13. Birthplace Pa

MOTHER 14. Maiden Name Katherine Bauman

15. Birthplace Pa

16 (a) Informant Miss Lea V. Gantz

(b) Address 2115 Belair Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21/44 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cem

Location Rural

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004-8 Orleans St

AUG 20 1944 Thurlington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1944, at 6:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944, to Aug. 18 1944, and that I last saw her alive on Aug. 18 1944.

Immediate cause of death	Duration
Myocarditis	
Due to: Adv. arteriosclerosis Nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Gantz M. D.

Address 1700 Eutaw Pl. Date signed Aug. 19-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9 4 W

G20085

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3224 Carlisle Ave.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Isidor Goldstrom

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Dora D. Goldstrom

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23 1875

8. AGE: Years 68 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Attorney

11. Industry or business

MOTHER / FATHER

12. Name Bernhard Goldstrom

13. Birthplace Germany

14. Maiden Name Sarah Rosenstein

15. Birthplace Balto. Md.

16 (a) Informant Mrs. Dora D. Goldstrom

(b) Address 3224 Carlisle Ave.

17 (a) Burial (b) Date thereof 8/21/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Balto. Hebrew

Location Balto. Md.

18 (a) Funeral director Harris Levy Strauss & Son

(b) Address 1804 Eutaw Place

19 (a) (Date rec'd by registrar AUG 20 1944) (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/1944 at 10:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/6/1944 to 8/18 1944 and that I last saw h~~e~~ alive on 8/18/1944.

Immediate cause of death: Pulmonary edema — Duration

Due to Myocardial insufficiency

Due to Coronary Artery Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Marriage Lowe M. D.

Address Sinai Hosp. Date signed 8/19/44

VS 150

MAKE ~~RESERVED FOR BINDING~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20086 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3739 Manchester Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3739 Manchester Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Frances Moore (Mary Frances Moore,)

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) March 3, 1874

8. AGE: Years 70 | Months 5 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Harford Co. Md.
(Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER
12. Name Samuel T. Moore
13. Birthplace Indiana

MOTHER
14. Maiden Name Sarah ~~Shepherd~~ Shepard
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs William Webster
(b) Address Pylesville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)
(c) Cemetery or crematory St. Ignatius
Location Hickory, Harford Co, Md.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.,

AUG 20 1944 Filed by registrar [illegible] for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1944, at 5 05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 17 1944, to Aug 18 1944, and that I last saw h.r. alive on Aug 18 1944.

Immediate cause of death	Duration
Diabetic acidosis	
Due to, Diabetes Mellitus	
Due to	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 8-19-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1940

G20087 Registered No. 6 mos

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave
(c) Hospital or institution: St Agnes' Hospital 27-17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4811 Park Heights Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. P. Doyle

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 215-09-9185

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Irene

6 (c) If alive, give age 1885 years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1884

8. AGE: Years	Months	Days	If less than one day
59	11	2	hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Bank Teller

11. Industry or business Maryland Trust

FATHER 12. Name Dennis Doyle

FATHER 13. Birthplace Scotland

MOTHER 14. Maiden Name Doyle

MOTHER 15. Birthplace Scotland.

16 (a) Informant Rev. William F. Doyle

(b) Address 8801 Harford Rd. 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Balto. City

18 (a) Funeral director C. Vernon Lemmon

(b) Address 4611 Park Heights Ave.

20 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1944, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1944 to 8/17 1944 and that I last saw h[illegible] alive on 8/17 1944

Immediate cause of death	Duration
Cardiac failure	
Due to Acute Coronary Thrombosis.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.

Address St Agnes Hosp Date signed 8/17/44

(over)

G20088

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

G20088 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. Gen'l. Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore #24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Rosedale St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Loretta Cain

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1902

8. AGE: Years 41 | Months 9 | Days 28 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Telephone operator

11. Industry or business

FATHER
12. Name Robt L. Cain
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Clark
15. Birthplace Maryland

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Bagby Md.

18 (a) Funeral director Geo. G. Finley
(b) Address Fulford & Gaylord Huntington Williams, Mgr.

19 (a) (Date rec'd by registrar) AUG 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/1944, at 2:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5/1944, to 8/18/1944, and that I last saw her alive on 8/15/1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension C-V Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: None

of autopsy: Subarachnoid hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address 1101 Medical Arts Bldg. Date signed 8/19/44

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20089 BALTIMORE CITY HEALTH DEPARTMENT G20089

CERTIFICATE OF DEATH 8 12

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson Sts.
(c) Hospital or institution Bon Secours.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Guyon Fall's Pkwy. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Francis Michael Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 1 | Months 21 | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Dr. James N. Collins

13. Birthplace N. Y.

MOTHER 14. Maiden Name Mary M Dolan

15. Birthplace Md

16 (a) Informant James Collins.

(b) Address 3001 Guyon Fall's Pkwy

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 20 44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location 4900 Edmondson Ave

18 (a) Funeral director H. Nitsky

(b) Address 4101 Edmondson Ave

19 (a) AUG 20 1944 (Date rec'd by registrar) (b) Huntington Williamsville Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1944, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1944, to 8/19 1944, and that I last saw him alive on 8/19 1944.

	Duration
Immediate cause of death: Bronchopneumonia	1 wk
Due to: Acute Otitis Media	3 wks.
Due to:	
Other Conditions: Internal Hydrocephalus (Include pregnancy within 3 months of death)	

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Raymond D Royer M.D.
Address 1500 Fenton St Date signed 8/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly.

G20090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8 30

Registered No. G20090

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 415 St. Joseph's Hospital, Gate Lane

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 - 4

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 417 N. Schroeder, Gate Lane (If rural give location)

(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME Emma T. Deaso

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Vincent R. Deaso

6 (c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): February 24-1880

8. AGE: Years: 64 | Months: 5 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER — 12. Name: William Rankle

13. Birthplace: Md.

MOTHER — 14. Maiden Name: Elizabeth Smith

15. Birthplace: Md.

16 (a) Informant: Vincent R. Deaso

(b) Address: 415 St. Joseph's Gate Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 21 1944 (month) (day) (year)

(c) Cemetery or crematory: New Cathedral

Location: Baltimore, Md

18 (a) Funeral director: J. S. Gaylord & Son

(b) Address: Eutaw Place & Lanvale St.

19 (a) MAY 20 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1944, at 8 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1944 to 8/18 1944 and that I last saw h[illegible] alive on 8/18/1944

Immediate cause of death: Right cerebral hemorrhage

Due to: arteriosclerosis

Due to:

Other Conditions: Hypertension

Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
3 days
9 years

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: [illegible]

Address 336 Mulberry St. Date signed 5/19/1944 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G20091 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fallsway & Eaton Sts
(c) Hospital or institution St. Agnes 15-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 Fresburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd R Brackett

3 (b) If veteran, name war: W.W 1
3 (c) Social Security Account No. 717-77356
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Mary Brackett
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept. 20. 1895
8. AGE: Years 48 | Months 11 | Days 0. | If less than one day hr. min.
9. Birthplace (Town, county, and State)
10. Usual Occupation Car tender
11. Industry or business
FATHER 12. Name Ludwell Brackett
13. Birthplace Va.
MOTHER 14. Maiden Name Jessie Clarke
15. Birthplace Va.
16 (a) Informant Tyler Lucille
(b) Address St Agnes Hospital
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-44 (month) (day) (year)
(c) Cemetery or crematory Oakwood
Location Richmond. Va.
18 (a) Funeral director D. Howard Strong
(b) Address 2707 W. North Ave.
19 (a) (Local registrar) (b) AUG 20 1944 Huntington Williams, M.D. Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20/44 19 , at 1:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1944 to 8/20 1944 and that I last saw him alive on 8/20 19 44
Immediate cause of death Respiratory failure
Toxemia
Due to Bilateral Pneumonia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: To

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature William J. Bryson M. D.
Address St Agnes Hosp Date signed 8/20/44

G20092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G20092 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Pagan Ave & Dukeland St.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 605 S. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME John S. Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-09-1374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife Ella Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1878

8. AGE: Years	Months	Days	If less than one day
66	2	5	hr. min.

9. Birthplace Middletown Fred. Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Eastern Aircraft

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Addie Haines

15. Birthplace Middletown, Md.

16 (a) Informant Estelle Moser

(b) Address 605 So. Payson, Baltimore Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-44 (month) (day) (year)

(c) Cemetery or crematory Lutheran Cemetery
Location Middletown, Md.

18 (a) Funeral director Bladhill Co.

(b) Address Middletown, Md.

19 (a) 8/21/44 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 19 44 at 6:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1944 to 8/20 1944 and that I last saw h. alive on 8/20 1944

Immediate cause of death	Duration
Bronchopneumonia	4 wk
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Bronchopneumonia Chronic Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W B & D J Taylor

Address Date signed 8/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G20093 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Govans, Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4515 Pt. George Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Dozier

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	W.

6 (b) Name of husband or wife Wm Dozier
6 (c) If alive, give age 70? years

7. Birth date of deceased (mo., day, yr.) ?

8. AGE: Years	Months	Days	If less than one day
60?			hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation N.W.
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Wm Dozier
(b) Address 4615 Pt. Geo. Ave.

17 (a) V (Burial, cremation, or removal) (b) Date thereof 8-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore, Md

18 (a) Funeral director Mrs George H. Holland
(b) Address 1631 Druid Hill Ave

19 (Date received) AUG 21 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 19 44 to 8/18 19 44
and that I last saw h[illegible] alive on 8/18 19 44

Immediate cause of death	Duration
Resp Fail.	
Due to Anemia, Arteriosclerosis Hypertension	
Due to Pneumonia, Lobar	
Other Conditions Incp. CA of Cervix.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature M. Jane Foley
Address Mercy Hosp Date signed 8/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1484

Registered No. G20094

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1406 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Ellamont St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Schumm Taylor.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife Wallas L. Taylor
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 9- 1874

8. AGE: Years	Months	Days	If less than one day
69	8	10	hr. min.

9. Birthplace Mt. Carmel Pa. (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business at Home.

FATHER
12. Name John C. Schumm
13. Birthplace Penna.

MOTHER
14. Maiden Name Margaret Brown
15. Birthplace Penna.

16 (a) Informant Miss Flossie Schumm
(b) Address 1591 Jackson St. Charleston W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Balto. Co. Md.

18 (a) Funeral director Robert S. Little
(b) Address 3700 Edmondson Ave

19 (a) AUG 21 1944 (b) Huntington Williamson, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1944 at 6.14 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 1 1944 to Aug 19 1944, and that I last saw h-m alive on Aug 18 1944.

Immediate cause of death Carcinoma of Uterus — Duration Dec. 1943

Due to with Metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Apr. 13-1944

Major findings of operation: Biopsy Carcinoma of Uterus

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Brown M. D.
Address 1663 N. Nor. St. Date signed 8/25/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

G20095

LB-89489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G20095

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19hrs. Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1915 Herbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Popp, Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4-1943

8. AGE: Years: 1 | Months: 6 | Days: 14 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Popp
13. Birthplace Md.

MOTHER
14. Maiden Name Therese Schmidt
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Park
Location Taylor Avenue

18 (a) Funeral director Albert L. Hilt Jr.
(b) Address 1606 N. Chester St.

19 (a) (Date received by registrar) AUG 21 1944 (Huntington Williams, M.D. Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1944, at 8.35A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1944 to Aug. 18 1944, and that I last saw him alive on Aug. 18 1944

Immediate cause of death: Postnatal Pneumonia — Duration: 2 hrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis W. Helfrich M. D.
Address B.C.H. Date signed 8-18-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

G20096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1572

Registered No. G20096

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Washington Blvd.
(c) Hospital or institution: Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) V

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1125 Monroe Circle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Kimble

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/12/44

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Melvin Kimble
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Gwendolyn Anderson
15. Birthplace Baltimore, Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 21 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/16/44 19 , at 2:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/12 19 44 to 8/16 19 44, and that I last saw h[illegible] alive on 19

Immediate cause of death — Duration

Due to ~~Uremia~~ cystic kidneys

Due to congenital renal insufficiency

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 919 Patapsco Ave Date signed

I 2092

G20097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20097 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2306 E. Monument St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2306 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Elizabeth Heathast

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. H. Heathast

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28 1875

8. AGE: Years	Months	Days	If less than one day
69	1	19	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Riggins
13. Birthplace Md

MOTHER 14. Maiden Name Susan J. Hutchinson
15. Birthplace Md

16 (a) Informant Mrs Pearl Heathast
(b) Address 2306 E. Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21-44 (month) (day) (year)

(c) Cemetery or crematory Westview Cem
Location Baltimore Md

18 (a) Funeral director Geo. L. Bayer Jr
(b) Address 1012 Hollins St

Aug 21 1944 Huntington for Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 1944, at 1015 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 12 1941, to Aug 16 1944, and that I last saw her alive on Aug 16 1944.

Immediate cause of death Cerebral Softening — Duration 7/17/44

Due to Arteriosclerotic Hypertension Cardio-Vascular Disease — Duration ?

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(c) Means of injury —

23. Signature Carl P. Rostring M. D.
Address 1316 W Lombard St Date signed Aug 19 44

G20098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43d.

G20098
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MADE AND RESERVED FOR RECORDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5415 Falls Road Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 63 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 W. Madison Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES HEDGMAN BALL

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Isaac L. Ball
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1856

8. AGE: Years	Months	Days	If less than one day
87	11	3	hr. min.

9. Birthplace Georgetown, Washington D.C.
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John G. Hedgman
13. Birthplace Virginis

MOTHER
14. Maiden Name Cecelis A. Stuart
15. Birthplace Unknown

16 (a) Informant Mr. Philip Stuart Ball
(b) Address Annapolis, Md.

17 (a) Burial (b) Date thereof 8/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lewinsville Church
Location McLean, Virginia. Cemetery.

18 (a) Funeral director H. W. Means & Son.
(b) Address 805 N. Calvert street

19 (a) AUG 21 1944 Huntington for Nathaniel Mc... Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1944, at 9.55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1935 to Aug 19 1944, and that I last saw h[illegible] alive on 8/19 1944

Immediate cause of death Myocardial infarction, Arteriosclerosis.

	Duration
Due to	Gradual
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. W. Hardy
Address 140 E Park Ave Date signed 8/22/44

G20099

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G20099
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1115 Sarah Ann St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Sarah Ann St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Samuel Washington

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex M

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 5, 1896

8. AGE: Years 48 | Months — | Days 17 13 | If less than one day hr. min.

9. Birthplace King Williams Co., Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Thomas Washington
13. Birthplace Va

MOTHER
14. Maiden Name Mary Washington
15. Birthplace Va

16 (a) Informant Helen Peaches (Niece)
(b) Address 1117 Winchester St. ~~1115 Sarah Ann St.~~

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/21/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. A. Co., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Mad. Ave.

19 (a) (Date received by Registrar) AUG 21 1944 Hunting Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1944, at 9.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944, to August 18 1944, and that I last saw ~~s~~he alive on August 18 1944.

Immediate cause of death

Cardiac Heart Failure — Duration 24 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Woodland M.D.
Address 841 Hamilton St. Date signed 8/18/44

G20100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20100 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 15

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1359 Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

3 (a) FULL NAME Jane Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male

5. Color or race: negro

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26, 1944

8. AGE: Years | Months: 1 | Days: 22 14 | If less than one day: hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James E. Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Ada Jackson
15. Birthplace S. C.

16 (a) Informant Ada Johnson
(b) Address 1359 N. Gilmor St.

17 (a) 8/18/44 (Burial, cremation, or removal) (b) Date thereof Burial (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Md.

18 (a) Funeral director Geo. G. Kelson
(b) Address 1303 Presstman St.

19 (a) (Signature of local registrar) Registrar

AUG 21 1944
Registrar of Vital Statistics, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1944, at 11½ P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1944, to Aug 18 1944, and that I last saw h[illegible] alive on Aug 18 1944.

Immediate cause of death Malnutrition — Duration

Due to

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hosp. Date signed 8/21/44

G20101

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 524

G20101 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3621 Buena Vista Ave.
(c) Hospital or institution: --
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3621 Buena Vista Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country --

3 (a) FULL NAME: Francis J. Quarles

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Edith Quarles

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 25, 1874

8. AGE: Years 70 | Months 2 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Laborer (Retired)

11. Industry or business

FATHER
12. Name: Francis Quarles
13. Birthplace: Richmond, Virginia

MOTHER
14. Maiden Name: Cathrine Brown
15. Birthplace: Ireland

16 (a) Informant: Mrs. J. T. Spurrier
(b) Address: 3621 Buena Vista Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-44 (month) (day) (year)
(c) Cemetery or crematory: Lorraine
Location: Baltimore, Md.

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

19 (a) ____ (Date rec'd by registrar) (b) Livingston Williams, M.D.
AUG 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18 1944, at 9:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 9 1944 to Aug 18 1944, and that I last saw h.i.m alive on Aug 18 1944

Immediate cause of death: Generalized Carcinomatosis — Duration: 3 mo

Due to: Carcinoma of Bladder

Due to: ____

Other Conditions: ____

(Include pregnancy within 3 months of death)
Date of operation: ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____
(e) Means of injury ____

23. Signature: Lawrence J. Shumaudy M. D.
Address 3711 Falls Rd Date signed 8-19-44

G20102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20102 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3520 Hilton Road

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County --

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3632 Hickory Avenue
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Anna T. Brown

3 (b) If veteran, name war --

3 (c) Social Security Account No. 220-07-2261

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife William H. Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1866

8. AGE: Years	Months	Days	If less than one day
78	3	11	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Seamstress (Ret.)

11. Industry or business

FATHER 12. Name William H. Keys

13. Birthplace Ireland

MOTHER 14. Maiden Name Elizabeth Owens

15. Birthplace Ireland

16 (a) Informant Thomas C. Keys

(b) Address 3632 Hickory Avenue

17 (a) Burial (b) Date thereof 8-23-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road Huntington Williamsport, Md.

19 (a) (b)
(Date received by registrar) Registrar

VS 18 AUG 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1944, at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944, to Aug 20 1944, and that I last saw h alive on Aug 18 1944

Immediate cause of death Cerebral Hemorrhage.

Due to Cardio-Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
1 wk.
10 yrs.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature Thos C. Dulebohn

Address 54 W 36 St. Date signed 8/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G20103

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Dan Drew Hosp 19

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary C Meredith

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 2, 1876

8. AGE: Years 68 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: William Jennings
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Susan
15. Birthplace: Baltimore, Maryland

16 (a) Informant: Mary G. Ewing
(b) Address: 101 N. Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23, 1944 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Maryland

18 (a) Funeral director: William Cook, Inc.
(b) Address: 211 S. Paul Street

19 (a) AUG 21 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1944, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1944 to 8-20 1944, and that I last saw h[illegible] alive on 8-20 1944.

Immediate cause of death: Pulmonary Edema — Duration

Due to: Congestive Heart Failure

Due to:

Other Conditions: Arteriosclerosis (PROBABLE)

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: L. Vogel, Jr. M. D.
Address: Bon Secours Hosp. Date signed 8-23-44

Appointed, Robert La Fetra Gibson M.D. 8/24/44

To be approved by Med. Exam.

G20104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

Registered No. G20104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN GEORGE KLEIN

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-03-8159

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 14th 1901

8. AGE: Years	Months	Days	If less than one day
43	4	25	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Sparrows Pt. Ship Yards

FATHER
12. Name Charles Klein
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Katherine Harthausen
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth Brannan
(b) Address 102-7th Ave. - Brooklyn Park

17 (a) Burial (Burial, cremation, removal) (b) Date thereof 8/23/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 (a) AUG 21 1944 (Date rec'd by registrar) Washington Metropolitan D.C.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17 1944, at 11 05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, Lobar, Right

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 8-19-44

G20105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G20105

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Ft. Holabird
(If outside city or town limits, write RURAL and give town)
(d) Street No. 236 Colgate Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN · FRANK BISHOP.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-4073

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Emma Bishop

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19th 1890

8. AGE: Years	Months	Days	If less than one day
53	11	07	hr. min.

9. Birthplace Bendersville Pa.
(Town, county, and state)

10. Usual Occupation Iron Worker

11. Industry or busines Leonard Construction Co

FATHER
12. Name John Bishop
13. Birthplace Pa.

MOTHER
14. Maiden Name Hannah Werner
15. Birthplace Pa.

16 (a) Informant Mrs Emma Bishop
(b) Address 236 Colgate Ave

17 (a) Burial (b) Date thereof 8/23/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)

(c) Cemetery ~~Crematory~~ Lutheran Church
Location Bendersville Pa.

18 (a) Funeral director William Cook Inc.
(b) Address 417 St. Paul st.

19 (a) AUG 21 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1944 at 11 20 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pulmonary embolism

Due to Fracture of vertebra and pelvis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-8-44 at 5 PM M.
(b) Where did injury occur? Davison Chemical Co Baltimore
(c) Did injury occur at home, on farm, industrial place, in public place? industrial While at work? Yes
(d) Means of injury fall 10 ft from scaffold

23. Signature H. J. Wollenweber M.D.
Medical Examiner.
Date signed 8-18-44

620106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 620106

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hosp.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 [5]
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 N. Montford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth A. Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced ~~Wife~~ Widow

6 (b) Name of husband or wife Charles L. Coleman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24-1873

8. AGE: Years 70 | Months 7 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name George Bosse
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Fleckenstein
15. Birthplace Md.

16 (a) Informant Margaret Knoche
(b) Address 414 N. Montford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 22/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem. Location Belair Rd.

18 (a) Funeral director John A. Milby
(b) Address 2234 Jefferson St.

19 (a) (Date rec'd by registrar) AUG 21 1944 (b) Huntington Williamson, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/18 1944 at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1944 to 8/18 1944 and that I last saw h.... alive on 19

Immediate cause of death Cardiac

Due to Diabetes Mellitus

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin Lawson M.D.
Address 1 Physicians Date signed 8/18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 58c

G20107

Registered No. 69360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Pennington Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lester McKinnon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife: Gertrude McKinnon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1910

8. AGE: Years 33 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Minnesota
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Walter McKinnon (d)
13. Birthplace Minnesota

MOTHER
14. Maiden Name Alma Johnson (d)
15. Birthplace Minnesota

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/44 (month) (day) (year)
(c) Cemetery or crematory Trinity Lutheran Cem.
Location O'Donnell St.

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

AUG 21 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19, 1944, at 8:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1944 to 8-19 1944, and that I last saw him alive on 8-19 1944.

Immediate cause of death Pulmonary edema — heart failure — Duration

Due to Rheumatic C.V.D.

Due to

Other Conditions Pleural effusions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary infarcts, pulmonary edema

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Sengmin M.D.
Address BCH Date signed 7/20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

G20108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No. G20108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 S. Greene St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S. Greene Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levy Gregg

3 (b) If veteran, name war

3 (c) Social Security Account No. 705-10-6285

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1944, at 9.45 A. M.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Florence Gregg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1906

8. AGE: Years	Months	Days	If less than one day
38	2	10	hr. min.

9. Birthplace Kingstree South Carolina (Town, county, and state)
10. Usual Occupation Longshoreman
11. Industry or business

FATHER
12. Name James Gregg
13. Birthplace Kingstree So Carolina

MOTHER
14. Maiden Name Dollie Washington
15. Birthplace Kingstree So Carolina

16 (a) Informant Florence Gregg Wife
(b) Address 222 S. Greene Street

17 (a) Burial (Burial, cremation, or removal) (b) Date [illegible] August 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph J. Brady
(b) Address 409 N. Mount Street

19 AUG 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive Cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D. Medical Examiner.
Date signed August 18, 1944

VS 151

G20109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 838

G20109 Registered No.

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Rayner Ave & Dunbar St.

(c) Hospital or institution: West Balto. Gen. Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED

(a) State Md. (b) County Ann Arundal

(c) City or town Greenhaven (If outside city or town limits, write RURAL and give town)

(d) Street No. #1 E. Westshore Rd (If rural give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country .....

3 (a) FULL NAME Mary AGNES JOHNSON

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles S. Johnson

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) April 1, 1877

8. AGE: Years	Months	Days	If less than one day
67	4	16	..... hr. ..... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name William Stewart

13. Birthplace Scotland

MOTHER

14. Maiden Name Kate Faxe

15. Birthplace Ireland

16 (a) Informant Mr. William Johnson

(b) Address 219 N. Patterson Pk. Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 -21- 44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Avenue & Broadway

19 (a) Date received AUG 21 1944 (Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/17 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1944 to 8/17 1944 and that I last saw h[illegible] alive on 8/17 1944.

Immediate cause of death	Duration
Cerebral Thrombosis	5 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Inconclusive pathology

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide .....

(b) Date of occurrence ..... at ..... M

(c) Where did injury occur? ..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)

(e) Means of injury .....

23. Signature Irving J. Taylor M.D.

Address W.B. & H. Date signed 8/17/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 139a

G20110 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Dennison St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Meredith (Sutton)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: Robert Sutton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-20-1924

8. AGE: Years: 19 | Months: 10 | Days: 27 | If less than one day: hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Jerry Meredith
13. Birthplace N. Y. C.

MOTHER
14. Maiden Name Bessie Robinson
15. Birthplace Baltimore Md

16 (a) Informant Jerry Meredith
(b) Address 417 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-21-1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park.
Location Baltimore Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (Date received by Registrar) AUG 21 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17 1944, at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22-1944, to 8-17-1944, and that I last saw her alive on 8-16-1944.

Immediate cause of death	Duration
Generalized Peritonitis	
Due to Perforating Appendicitis	
Due to Disease — Pyoadenopathy	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Pyoadenopathy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Wilson
Address 1514 Dennison St. Date signed 8/17/44 M. D.

G20111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 d

Registrar's No. G20111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 347 Camel St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jas Edward Carrington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	M

6 (b) Name of husband or wife Annie Carrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-75 or 7-26-1875

8. AGE: Years	Months	Days	If less than one day
69	—	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Univ. of Md. Dental School

FATHER
12. Name Lawrence Carrington
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Harrison
15. Birthplace Virginia

16 (a) Informant Annie Carrington
(b) Address 347 Camel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-22-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md

18 (a) Funeral director Charles G. Cooper
(b) Address 6728 W. Carrollton Ave.

19 AUG 21 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 17, 1944, at 7:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 10, 1944, to August 17, 1944, and that I last saw him alive on August 17, 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Cerebral Hemorrhage	10 days
Due to Hypertensive Cardio-Vascular Disease	12 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dean Pasihal, M. D.
Address University Hosp. Date signed

Pasihal

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G20112

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4112 Southern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4112 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN R. TALBOTT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Anna D. Talbott nee Kraemer. 6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1915

8. AGE: Years	Months	Days	If less than one day
28	7	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Patrolman
11. Industry or business City Police Force

FATHER
12. Name Wm. H. Talbott
13. Birthplace Parkton Balto. Co. Md.

MOTHER
14. Maiden Name Hdr Peregoy
15. Birthplace Foreston Baltimore, Co. Md.

16 (a) Informant Mrs. J. R. Talbott
(b) Address 4112 Southern Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug. 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Foreston Meth. Cem.
Location Parkton, Md.

18 (a) Funeral director Lasacker Funeral Home
(b) Address 7401 Belair Road

AUG 21 1944 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19th 1944, at 1 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 13 1944 to Aug. 19 1944, and that I last saw him alive on Aug. 18 1944

Immediate cause of death: Lobar Pneumonia — Duration 6 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Williamson A. L. Williamson M. D.
Address 5713 Bel Air Rd. Date signed 8-20-44

Balt. 6.

32613 G20113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 39C

G20113 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the to the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address:
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Pasadena (If outside city or town limits, write RURAL and give town)
(d) Street No. Md. Pleasant Beach (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon Warrington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-10

8. AGE: Years	Months	Days	If less than one day
33	9	13	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business Associated Transport

FATHER
12. Name Samuel Warrington
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Deaver
15. Birthplace Balto. Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18 (a) Funeral director Earl L. Hess
(b) Address 715 Eight St Washington, D.C.

19 (a) [illegible] (Signature of local registrar) [illegible] M.D.

AUG 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1944 at 6 25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 2 1944 to Aug 19 1944 and that I last saw h[illegible] alive on Aug 19 1944

Immediate cause of death	Duration
encephalitis	
Due to Rocky mnt. Spotted Fever	
Due to	
Other Conditions Bilat LLL pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury Abraham Genesin

23. Signature [illegible] M.D.
Address 7 Hopkins Date signed 8-20-44

G20114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G20114 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 918 S Charles ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 918 S Charles St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Amos

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-1623

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annie M. Amos

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 1st 1883

8. AGE: Years 61 | Months 2 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Helper

11. Industry or business Retail Store Fixtures

FATHER 12. Name Unknown

13. Birthplace ?

MOTHER 14. Maiden Name Unknown

15. Birthplace ?

16 (a) Informant Mrs Annie M. Amos

(b) Address 819 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23, 1944 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Annapolis Blvd AACo

18 (a) Funeral director Carl L. Hess

(b) Address 15 Light St.

19 (a) AUG 21 (Date rec'd by registrar) (b) Huntington Wilkins, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1944, at 8 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Bratton M.D. (Medical Examiner.)

Date signed August 21 1944

G20115

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

G20115
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie B. Watson.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White. | 6 (a) Single, married, widowed, or divorced Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 3-1880.

8. AGE: Years 64 | Months 6 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county and state)

10. Usual Occupation House Work -

11. Industry or business At home.

FATHER
12. Name James Watson.
13. Birthplace Md.

MOTHER
14. Maiden Name Martha R. Coleman.
15. Birthplace Kent Co. Md.

16 (a) Informant Mrs. Abram Watson.
(b) Address 1923 Edmondson Ave.

17 (a) Burial. (b) Date thereof Aug. 23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto. Co. Md.

18 (a) Funeral director Charles F. Schwab.
(b) Address 505 N. Monroe St.

19 AUG 21 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1944 at 12:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1944 to Aug 20 1944 and that I last saw her alive on Aug 20 1944

Immediate cause of death Chronic Cardiac Vas Anem — Duration 8 yrs

Due to

Due to

Other Conditions Hemoglobin

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ernest H. Kahn
Address 1735 Poplar St Date signed 8/21/44 D.

MAKE RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20116
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 408 N. Monroe St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 N. Monroe St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J. Corcoran.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single.

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 19-1875.

8. AGE: Years	Months	Days	If less than one day
69	5	1	hr. min.

9. Birthplace Charleston - S.C.
(Town, county, and state)

10. Usual Occupation House Work -
11. Industry or business - at home.

FATHER
12. Name James Corcoran.
13. Birthplace Charleston - S.C.

MOTHER
14. Maiden Name Catherine McGuire.
15. Birthplace Ireland

16 (a) Informant Mrs. Anna Cole.
(b) Address 408 N. Monroe St.

17 (a) Removal (b) Date thereof Aug. 21-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Secret Nebit Cem.
Location Charleston, S.C.

18 (a) Funeral director Charles J. Schuyler.
(b) Address 505 N. Monroe St. Baltimore, Md.

19 (a) AUG 21 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1944, at 2 40 P.M.

21. I certify that I took charge of the remains described above, held an Inquestion thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Scarborough M.D.
Medical Examiner.
Date signed August 21 1944

G20117

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. A. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days) 3 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2504 Albion Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Greenfelder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace W. B. A. H.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Henry Greenfelder
13. Birthplace Balt. Md.

MOTHER
14. Maiden Name Anna Helen Brunn
15. Birthplace Balt. Md.

16 (a) Informant Mrs. Geo. Greenfelder
(b) Address 2504 Albion Ave

17 (a) Burial (b) Date thereof Aug 21 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Baltimore Md

18 (a) Funeral director J. Freeman & Son
(b) Address 3 E. S. Broadway

19 (a) (b) Huntington Williams M.D.
Registrar

AUG 21 1944
VS 11a

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 19 1944, at 10:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1944, to Aug 19 1944, and that I last saw him alive on Aug 19 1944.

Immediate cause of death prematurez

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M. D.
Address WBAH Date signed 8/20/44

G20118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20118 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynolds & Dukeland St
(c) Hospital or institution West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Cleveland St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Kunz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W.	Married

6 (b) Name of husband or wife Martha M. Kunz
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Apr 3. 1870

8. AGE: Years	Months	Days	If less than one day
74	4	17	hr. min.

9. Birthplace Switzerland (Town, county, and state)
10. Usual Occupation Hand Embroiderer
11. Industry or business Lion Bros

FATHER
12. Name Henry Kunz
13. Birthplace Switzerland

MOTHER
14. Maiden Name Regina ?
15. Birthplace Switzerland

16 (a) Informant Martha M. Kunz
(b) Address 1729 Cleveland St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23. 1944 (mo.) (day) (yr.)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mrs. Mrs. John F. Feifel & Son
(b) Address 801 W. Fayette St

19 (a) (Date received by registrar) AUG 21 1944

Huntington, West Virginia, Mar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/20 1944, at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1944 to 8/20 1944, and that I last saw h[illegible] alive on 8/20 1944.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to Cerebral Thrombosis	1 wk.
Rt. Hemiplegia	
Due to N C V D	
Other Conditions Diabetes Mellitus Dysentery	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving J. Taylor M. D.
Address WBG H Date signed 8/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. G20119

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2034 Madison ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 Madison ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Levi T. Moore

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-4545

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rosa A. Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1874

8. AGE: Years 70 | Months 3 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Austin Texas
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Public Schools

FATHER
12. Name Aaron Moore
13. Birthplace Austin, Texas

MOTHER
14. Maiden Name Theresa M-Cloud
15. Birthplace Austin, Texas

16 (a) Informant Mrs Rosa A. Moore
(b) Address 2034 Madison ave

17 (a) Burial (b) Date thereof 8-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Balto Co Md

18 (a) Funeral director Jno Geo H. Holland
(b) Address 1631 Edmondson ave

19 (a) Aug 21 1944 (b) Huntington-Williams M.P.
(Date filed by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1944, at 630 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 18 1944 and that I last saw h[illegible] alive on Aug 18 1944

Immediate cause of death Coronary Occlusion — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Rhett

Address [illegible] Date signed Aug 21 1944 M. D.

G20120

BALTIMORE CITY HEALTH DEPARTMENT X 1944

CERTIFICATE OF DEATH

Registered No. G20120

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Somerset
(c) City or town Crisfield, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie May Fleetwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Wm. F. Fleetwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/1866

8. AGE: Years 57 | Months 8 | Days 2 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name John Snyder
13. Birthplace Md.

MOTHER — 14. Maiden Name Hattie Coleman
15. Birthplace Md.

16 (a) Informant Wm. E. Fleetwood
(b) Address Crisfield, Md

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8/22/44 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial Pk.
Location Hwy for Age.

18 (a) Funeral director Jas. L. McCully
(b) Address 120 E. Fremont Ave.

19 (a) (Date received by registrar) (b) Huntington for Williams, M.D. Registrar

VS AUG 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/19 1944, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/9 1944 to 8/19 1944, and that I last saw h.e alive on 8/19 1944.

Immediate cause of death: Chronic lymphoid leukemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Myers, M.D.
Address Md. Gen. Hosp. Date signed 8/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 A

Registered No. G20121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E. Pratt St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1714 E. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Shriver

3 (b) If veteran, name war

3 (c) Social Security Account No. No.

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Oscar.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 19 1885

8. AGE: Years 59 | Months 4 | Days 0 | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Charles Vollmer

13. Birthplace Germany ?

MOTHER 14. Maiden Name Emma

15. Birthplace Balto.

16 (a) Informant Oscar J. Shriver Martin Plass

(b) Address 1714 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 22 44 (month) (day) (year)

(c) Cemetery or crematory Balto.

Location E. North Ave

18 (a) Funeral director Mart. W. Dippel's Sons

(b) Address 37 S. Ann St

19 (a) AUG 21 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1944 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 19 44 to Aug 19 1944 and that I last saw her alive on Aug 19 1944.

Immediate cause of death	Duration
General arteriosclerosis	1 yr
Chr myocarditis	1 yr
Due to Coronary Thrombosis	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. L. Solomon

Address 129 E. Brevay Date signed 8/20/44

G20122 3235 BALTIMORE CITY HEALTH DEPARTMENT 1169 G20122

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARK "RESERVED FOR PENDING"

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital. 57
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21days
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Batavia Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Miller Harry F. Miller

3 (b) If veteran, name war

3 (c) Social Security Account No. 188-10-3374

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 5 1884

8. AGE: Years	Months	Days	If less than one day
60	6	15	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Shoe Salesman

11. Industry or business

FATHER 12. Name Conrad Miller

13. Birthplace Balto

MOTHER 14. Maiden Name Alfreda Goetzinger

15. Birthplace Germany

16 (a) Informant Anna Miller

(b) Address 3200 Batavia Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 24 44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4300 Belair Rd.

18 (a) Funeral director Martin W. Dugan

(b) Address 37 S. Carey St.

AUG 21 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-44. 19 , at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31-44 19 to 8-20-44. 19 and that I last saw him alive on 8-20-44 19

Immediate cause of death	Duration
Carcinoma of Pancreas	
Due to	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)

Date of operation 8-15-44.

Major findings of operation: Ca. of head of pancreas & Cholelithiasis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L. Vanni, M.D.

Address St. Joseph's Hosp. Date signed 8-20-44

G20123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1-59

G20123
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3611 Cottage Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Roots
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3611 Cottage Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Premature — Ratliff

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8

8. AGE: Years [redacted] Months [redacted] Days [redacted] If less than one day 6 hr. — min.

9. Birthplace 3611 Cottage Ave
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Ratliff
13. Birthplace Ky

MOTHER
14. Maiden Name Ruth Bailey
15. Birthplace Ky

16 (a) Informant Mother
(b) Address 3611 Cottage Ave

17 (a) Burial (b) Date thereof Aug 24 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Paintsville, Kentucky

18 (a) Funeral director Young Byers
(b) Address 5005 Park Heights Avenue

19 (a) (b) Registrar
Date rec'd by registrar AUG 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1944 at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1944 to Aug 21 1944 and that I last saw h[illegible] alive on Aug 21 1944

Immediate cause of death — Premature - Birth — Duration —

Due to —

Due to

Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Mills M. D.
Address 5776 Park Way Date signed Aug 21 44

G20124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RESERVED FOR BINDING MARGIN

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5511 Stonington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5511 Stonington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Esther Suter

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Samuel Henry Suter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1, 1862

8. AGE: Years	Months	Days	If less than one day
82	6	17	hr. min.

9. Birthplace Huntington, Pa.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Ephriam McColloum
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rebecca Hildebrand
15. Birthplace Germany

16 (a) Informant Mr. Roland Suter
(b) Address 5509 Stonington Ave.

17 (a) Burial (b) Date thereof Aug. 21, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller & Corrocan
(b) Address 4520 Liberty Heights Ave.

AUG 21 1944 Hunter for Williams M.D.
(Date) (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 5, 1941 to Aug 18 1944, and that I last saw her alive on Aug 18 1944.

Immediate cause of death Arteriosclerosis — Duration 5 Yrs
Due to Chronic Myocarditis — 2 Yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. B. Miller
Address 2757 W. North Ave. Date signed Aug 19 1944 D.

G20125 G20125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 Jeffery St (25) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert C. Giles

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-14-0480

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced [redacted] Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 2-1924

8. AGE: Years	Months	Days	If less than one day
19 20	9	17	hr. min.

9. Birthplace Dorsey a. A. County (Town, county and state)
10. Usual Occupation Laborer
11. Industry or business Lork Insulator Co

FATHER
12. Name Wilbert C Giles
13. Birthplace Dorsey a. A County

MOTHER
14. Maiden Name Lillie Johnson
15. Birthplace Cumberland Md

16 (a) Informant Mrs Wm. Giles
(b) Address 125 Jeffery St

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] Aug 23-44 (month) (day) (year)
(c) Cemetery or [illegible] Zion Cemetery
Location Dorsey Md.

18 (a) Funeral director Milton Schelling
(b) Address 3914 S. Hanover St

19 (a) (Date received by registrar) AUG 21 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1944, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10 1944, to Aug. 19 1944, and that I last saw h[illegible] alive on Aug. 19 1944.

Immediate cause of death Staphylococcus aureus septicemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul D. Lubato M. D.
Address 1213 Light St. Date signed 8/20/44

20126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20126

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 Charlcote Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Charlcote Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lt. Bernard Wesley Donohue

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3-1905

8. AGE: Years	Months	Days	If less than one day
38	11	16	hr. min.

9. Birthplace Clarksburg W. Virginia (City, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name Frank Donohue
13. Birthplace Clarksburg W. V.

MOTHER
14. Maiden Name Anna Campbell
15. Birthplace Clarksburg W. V.

16 (a) Informant Mrs. W. Donohue
(b) Address 12 Charlcote Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 22-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Frank Della Nave
(b) Address 52 N. Morby St

19 (a) (Signature of undertaker) (b) Hamilton or Williamson, Md.

AUG 22 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1944, at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to 8-19 1944 and that I last saw h. alive on 8-19 1944.

Immediate cause of death Bronchogenic Carcinoma metastasis — Duration 6 Mos.

Due to Carcinoma Bronchogenic — 8 mos.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Donohue M. D.
Address Medical Arts Bldg Date signed

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20127 | 318 | G20127 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline
(c) Hospital or institution: St. Joseph
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½D
(e) Length of stay in Baltimore (yrs., mos., or days) 48-7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 S. Conklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Rothe
3 (b) If veteran, name war
3 (c) Social Security Account No. 212-10-1233

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Grace B. Rothe
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan. 19, 1896

8. AGE: Years	Months	Days	If less than one day
48	7	b	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Maintanence Man
11. Industry or business American S. & R. Co.

FATHER
12. Name Ernest C. Rothe
13. Birthplace Baltimore

MOTHER
14. Maiden Name Bertha Keil
15. Birthplace Germany

16 (a) Informant Ernest O. Rothe
(b) Address 1116 S. Conklin

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/44 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location 6115 O'Donnell St.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 22 1944

MEDICAL CERTIFICATION

15

20. DATE OF DEATH Aug 19 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1944 to Aug 19 1944 and that I last saw h.m alive on Aug 19 1944

Immediate cause of death	Duration
Uremia	
Due to Chronic Nephritis & Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St. Joseph Hospital Date signed 8-19-44

20128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1571

G20128
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: W. B. & H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 29 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balt. Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 346 Oberle Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby Boy Walton.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 1 | If less than one day: 29 hr. ..... min.

9. Birthplace W. B. & H.
(Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER 12. Name George Henry Walton
13. Birthplace Balt. Md.

MOTHER 14. Maiden Name Ora agnes Clark
15. Birthplace Waterbury, Conn.

16 (a) Informant.....
(b) Address

17 (a).....(b) Date thereof.....
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location UNIVERSITY MEDICAL SCHOOL AUG 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address.....

AUG 22 1944 (Date received by registrar) (Signature) Huntington Williams M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 18 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 17 1944, to Aug. 18 1944, and that I last saw him alive on Aug. 17 1944

Immediate cause of death	Duration
Congenital Heart Disease	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Spencer Hartman M. D.
Address 2231 Eastern Ave. Date signed Aug 22 1944

2094

G20129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G20129

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 da
(e) Length of stay in Baltimore (yrs., mos., or days) 5 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town ~~Balto~~ Chase
(If outside city or town limits, write RURAL and give town)
(d) Street No. –
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		5–	hr. min.

9. Birthplace W. B. D. H.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Edward Carroll
13. Birthplace Ann Arundel Co, Md

MOTHER
14. Maiden Name Wilhelmina Lillian Frank
15. Birthplace Balt. Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 22, 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1944, at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944, to Aug 19 1944, and that I last saw h[illegible] alive on Aug 19 1944.

Immediate cause of death	Duration
premature	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Taylor
Address W 39 H Date signed 8/19/44 D.

VS 150

2095

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

G20130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 638

Registered No. G20130

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 d
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 E Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Connolly

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John T Connolly

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1879

8. AGE: Years	Months	Days	If less than one day
65	7	9	hr. min.

9. Birthplace Baltimore Co Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Dieter
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Snyder
15. Birthplace Germany

16 (a) Informant John Connolly husband
(b) Address 2313 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Philip Henry Stone
(b) Address 4 Aug 22 1944 Calvert St

19 (Date rec'd by registrar) Hampton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21/44 19 , at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/29/44 19 , to 8/21/44 19 , and that I last saw h-- alive on 8/21/44 19 .

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerotic C.V. disease	
Due to	
Other Conditions Hypertension treated by Thyroidectomy (Include pregnancy within 3 months of death)	

Date of operation 8/7/44
Major findings of operation: Hypertension
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J C Guyther M.D.
Address Mercy Hosp Date signed 8/21/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G20131

G20131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4419 Harford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Cooper Jr.

3 (b) If veteran, name war: WS
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) ~~Single~~ married, ~~widowed, or~~ divorced: Married
6 (b) Name of ~~husband or~~ wife: Margaret L. Cooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1878

8. AGE: Years 65 | Months 11 | Days 20 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual Occupation: Clicker
11. Industry or business: B & O R-R.

FATHER
12. Name: Wm G. Cooper Sr
13. Birthplace: Balto. Md.

MOTHER
14. Maiden Name: Margaret A. Collison
15. Birthplace: Md.

16 (a) Informant: Mrs Forsyth Pazzas
(b) Address: 5400 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory: Morland Park
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc
Address: 117 St. Paul St

19 (a) AUG 22 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1944, at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 20 1944, to Aug. 21 1944, and that I last saw him alive on Aug. 21 1944.

	Duration
Immediate cause of death: Arteriosclerotic cardio-vascular disease with cardiac hypertrophy	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul L Lukats M. D.
Address 1213 Light St. Date signed 8/21/44

329571

20132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 W Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Josiah Nance

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 - ? - 76

8. AGE: Years 68 | Months | Days | If less than one day: hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Public Worker W.P.A.

11. Industry or business

FATHER
12. Name Solomon Nance
13. Birthplace N. C.

MOTHER
14. Maiden Name Rachael ?
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-23-44 (month) (day) (year)
(c) Cemetery or crematory Warren, Ohio
Location Ohio

18 (a) Funeral director Mrs. Katie D. Williams
(b) Address 2 N. Schroeder St.

19 (a) AUG 22 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 154

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1944 at 8 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Aug 21 1944 and that I last saw him alive on Aug 21 1944

Immediate cause of death: ? pul. embolus — Duration: 5 yrs

Due to: Arteriosclerotic heart

Due to: disease, cardiac

Other Conditions: insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Theory

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Bumingham M. D.

Address JHH Date signed 8/24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20133

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

93d

G20133 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 470 N Parrish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 470 N. Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GRACE JOHNSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 94 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Lancaster Co., Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Daisy Queen

(b) Address 407 N. Parish St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-23-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Memorial

Location Baltimore, Md.

18 (a) Funeral director Mrs. Katie B. Williams

(b) Address 322 N. Schroeder St.

19 (a) AUG 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 19 44, at 11:30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis

cardiorenal

Due to disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ... at ... M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? ... While at work?

(d) Means of injury

23. Signature W. L. Wollenweber M.D.
Medical Examiner.

Date signed 8-20-44

G20134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

G20134 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 Tyson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Tyson St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee Strong

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1889

8. AGE: Years 55 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name unknown
13. Birthplace N. C.

MOTHER 14. Maiden Name Betsy
15. Birthplace N. C.

16 (a) Informant Ulysses Strong
(b) Address 2328 McCulloh St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 AUG 22 1944 Huntington Williams M.D. (Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1944, at 2: P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1944 to Aug 21 1944, and that I last saw h/ alive on Aug 20 1944.

Immediate cause of death Heart Failure — Duration Several months

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1543 Pennsylvania Ave Date signed 8-22-44

G20135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20135 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARRIAGE RESERVED FOR READING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23days
(e) Length of stay in Baltimore (yrs., mos., or days) 23days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Raspeburg (If outside city or town limits, write RURAL and give town)
(d) Street No. Hamilton Ave. & Koppelman Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick Koppelman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Violo J. Koppelman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26th. 1895

8. AGE: Years	Months	Days	If less than one day
48	8	24	hr. min.

9. Birthplace Baltimore, Co. Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Truck Farm

FATHER
12. Name John H. Koppelman
13. Birthplace Baltimore Co. Maryland

MOTHER
14. Maiden Name Annie Schaub
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Frederick Koppelman
(b) Address Raspeburg, Balto. 6 Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 23. 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) AUG 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-44. 19 , at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28-44 19 , to 8-20-44 19 , and that I last saw him alive on 8-20-44 19 .

Immediate cause of death Peritonitis — Duration

Due to Acute Hemorrhagic Pancreatitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-10-44

Major findings of operation: Acute pancreatitis with 2ndary intest. obstruction. & peritonitis.

Date of autopsy: Same as operation.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank L Vanni, M.D. M. D.
Address St. Joseph's Hosp. Date signed 8-20-44

G20136 KLINEDINST

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G20136 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 Washington Blvd (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Carol Klinedinst

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 - 8 - 42

8. AGE: Years	Months	Days	If less than one day
1	8	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Gilbert Klinedinst
13. Birthplace York, Pa

MOTHER
14. Maiden Name Katharine Warren
15. Birthplace Knoxville Tenn

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/22/44 (month) (day) (year)
(c) Cemetery or crematory Medon Rydell
Location Loch Raven Blvd
18 (a) Funeral director Edward Fowler
(b) Address 2309 Loch Raven Blvd
19 (a) (b)

AUG 22 1944 Registrar
VS 158 Huntington for Hillsboro, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 - 19 1944 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17 1944 to 8-19 1944.
and that I last saw her alive on 8 19 1944.

Immediate cause of death respiratory failure

Due to Poliomyelitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation 8-19-44

Major findings of operation: aspiration

of autopsy:

Duration
2 da.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp Date signed 8-20

G20137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

G20137
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Room 7 4803 Bryan Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State V (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4808 Norwood ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeffrey Le Roy Orndorff

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 4 1943

8. AGE: Years	Months	Days	If less than one day
1	2	17	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Charles Robert Orndorff
13. Birthplace Sheppardstown W. Va.

MOTHER
14. Maiden Name Mildred Whitehurst
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles R. Orndorff
(b) Address 4808 Norwood Ave.

17 (a) Burial (b) Date thereof 8/23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) [illegible] 22 1944 Huntington-Williams, Mort.
(Date rec'd by registrar) (Name and address of mortician)

VS 151 8 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21- 1944, at 3 15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-21-44 at 2.15 P. M.
(b) Where did injury occur? Room 7 4803 Bryan Park Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? —
(d) Means of injury Fell into a fish pond.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-22-44

G20138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E G20138

Registration No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore CATONSVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. 811 Braeside Rd. (Balto #29) (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ludwig Zinser

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-03-2853

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dorothy Zinser

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1885

8. AGE: Years 59 | Months 6 | Days 6 | If less than one day: hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business S & N Katz (jewelers)

FATHER
12. Name Adolph Zinser
13. Birthplace Germany

MOTHER
14. Maiden Name Clementine Neuberger
15. Birthplace Germany

16 (a) Informant Mrs Dorothy Zinser
(b) Address 811 Braeside Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23rd 1944 (month) (day) (year)
(c) Cemetery Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Pennsylvania Ave. Williamsport, Md.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20-44 19 , at 2-A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-31-44 19 to 8-20-44 19 , and that I last saw him alive on 8-20-44 19 .

Immediate cause of death	Duration
Cardiac Failure	
Due to Chronic Myocarditis	
Due to	
Other Conditions Papilloma of bladder	

(Include pregnancy within 3 months of death)

Date of operation 8-2-44 and 8-3-44

Major findings of operation: Bladder tumor (papilloma)

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. W. Traynor M. D.
Address 811 Cecil Way Date signed 8/20/44

G20139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20139 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Ruxton, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Malvern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Thomas S. Long. (Rev. Thomas Stran Long)

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Male M.

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mary May Long

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 5. 1864

8. AGE: Years 80 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Minister, Methodist

11. Industry or business

FATHER
12. Name Rev. Thomas W. Long.
13. Birthplace Balto.

MOTHER
14. Maiden Name Mary M. Baage
15. Birthplace Balto.

16 (a) Informant Mr. Wm. H. Long
(b) Address 6308 Bellona Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) (Date rec'd by registrar) AUG 22 1944 (b) Huntington Williamsport, Md.

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1944 at 8 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-9-44 19 to 8-20-44 19, and that I last saw him alive on 8-20-44 19.

Immediate cause of death Cardiac failure — Duration

Due to Pneumonia.

Due to Hypertensive C.V.D.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. Carl Myers

Address MD. Gen. Hosp. Date signed 8/20/44

G20140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G20140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES WATERS

3 (b) If veteran, name war: Canadian War I

3 (c) Social Security Account No. 213-09-5054

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Katherine McDonnell

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 51 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace County Wexford, Ireland (Town, county, and state)

10. Usual Occupation Pipe fitter

11. Industry or business Mail Order House

FATHER
12. Name Michael Waters
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Conklin
15. Birthplace Ireland

16 (a) Informant Mrs. James Waters
(b) Address 2114 W. Lexington Sts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Thos. J. Kenny
(b) Address Hollins & Gilmor
Huntington Williams M.D.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 19 44 at 9:30 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 8-20-44

G20141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G20141
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1137 S. Sharp St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 3
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 S. Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lydia Lottie May Zelder

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1943

8. AGE: Years	Months	Days	If less than one day
	11	25	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Quincy Zelder
13. Birthplace Sumter S. C.

MOTHER
14. Maiden Name Annie May Porter
15. Birthplace Sumter S.C.

16 (a) Informant Quincy Zelder
(b) Address 1137 S Sharp

17 (a) Burial (b) Date thereof Aug 22 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location A.A. Co Md
18 (a) Funeral director Isaiah R Trowbridge
(b) Address 105 W Montgomery Street
19 (a) (b) Huntington Williams, M.D.
(Date received by registrar)
AUG 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1944 at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1944 to 8/20 1944, and that I last saw h[illegible] alive on 8/20 1944

Immediate cause of death	Duration
Acute Anemia	5 days
Due to (Pernicious)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 8/21/44

G20142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 k

G20142 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 908 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Holmes

3 (b) If veteran, name war

3 (c) Social Security Account No. 249-18-3789

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Seperated

6 (b) Name of husband or wife: Ruth

6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 12-25-1900

8. AGE: Years 43 | Months 7 | Days 24 | If less than one day ... hr. ... min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name John Holmes

13. Birthplace Va

MOTHER 14. Maiden Name Louise Murray

15. Birthplace Va

16 (a) Informant Florence Holmes (S)

(b) Address 1421 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof ... (month) (day) (year)

(c) Cemetery or crematory Mt Vernon Cemetery

Location Whitestone Va

18 (a) Funeral director Charles G. Cooper

(b) Address 572 N. Carrollton Ave

19 (a) AUG 22 1944 Huntington Williams M.D. (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1944, to 8/19 1944 and that I last saw h... alive on 8/19 1944.

Immediate cause of death

Pulmonary T.B. — Duration 6 Mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carsan C. Johnson M. D.
Address 1802 Penna Ave Date signed 8/21/44

620143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168 620143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Les Rice

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Evelyn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1903

8. AGE: Years	Months	Days	If less than one day
41 47	4	7	hr. min.

9. Birthplace Anderson S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Revere Copper & Brass Co.

FATHER
12. Name Newton Rice
13. Birthplace Anderson S.C.

MOTHER
14. Maiden Name Frances
15. Birthplace Anderson S.C.

16 (a) Informant Evelyn Rice
(b) Address 428 N. Carey St.

17 (a) Burial (b) Date thereof 8-23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md.

18 (a) Funeral director Charles S. Cooper
(b) Address 612 N Carrollton Ave.

19 (a) (Date rec'd by registrar) AUG 22 1944 (b) Registrar

VS 151

MEDICAL CERTIFICATION 10:05

20. DATE OF DEATH August 18, 1944, at A. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull.
Homicide

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-11-44 at 3 P. M. Revere Copper & Brass Co.
(b) Where did injury occur? Harbour + Eastbourne Aves
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial. While at work? Yes.
(d) Means of injury Struck on head with a hoe.

23. Signature H L Wollenweber M.D.
Medical Examiner.
Date signed August 18, 1944.

Hunterston Williams, M.D.

G20144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G20144 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 N. Decker Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA Regina GALLUP

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife James E. Gallup
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1877

8. AGE: Years	Months	Days	If less than one day
66 67	10	5	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James E. Gallup, Sr.
13. Birthplace Wilmington Del.

MOTHER
14. Maiden Name Elizabeth Hoffberg
15. Birthplace Germany

16 (a) Informant Elizabeth Buckmaster
(b) Address 1209 N. Decker Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23 1947 (month) (day) (year)
(c) Cemetery or crematory Baltimore Mem. Park
Location Hollins Ave Ext.

18 (a) Funeral director Wendell J. Hoppel
(b) Address 317 S. Highland Ave

19 (a) AUG 22 1947 (Date received by registrar) (by) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1947, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 8-20-47

VS 151

G20145
32936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 0

Registered No. G20145

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. 59 Webster St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Lawrence Little

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	engaged

6 (b) Name of husband or wife Madaline Little
6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 11-5-09

8. AGE: Years	Months	Days	If less than one day
34	9	17	....hr. ....min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation G. L. Martins
11. Industry or business

FATHER
12. Name John Little
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Nagel
15. Birthplace N.J.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25/1944 (month) (day) (year)
(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md.

18 (a) Funeral director H. Bankard & Son
(b) Address Westminster, Md.

19 AUG 22 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1944 at 6 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11- 1944 to 8-21 1944, and that I last saw h[illegible] alive on 8-21- 1944

Immediate cause of death	Duration
Uremia	
Due to (a) Renal Tuberculosis	2 mos
Due to	
Other Conditions ? Sulfa drug nephritis	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operations:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature H. Cleveland Wright M. D.
Address Johns Hopkins Date signed 8-22-44

G20146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G20146

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution University Hospital 12-04
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1908 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ziegler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Harry Ziegler
6 (c) If dead, give age 56 years

7. Birth date of deceased (mo., day, yr.) Dec 17 th 1887

8. AGE: Years	Months	Days	If less than one day
56	8	3	hr. min.

9. Birthplace Balto. City, Maryland
(Town, County, and State)

10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Carbach
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Capio
15. Birthplace Balto. Md.

16 (a) Informant Mary J. Ziegler
(b) Address 1908 Greenmount Ave

17 (a) Baltimore Burial (b) Date thereof Aug 24 —
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2014 E. Baltimore
AUG 22 1944 Huntington Williams, M.D.
(Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-20 1944, at 7:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1944, to 8-20 1944, and that I last saw her alive on 8-20 1944.

Immediate cause of death Uremia — Duration

Due to Cardiovascular Renal Disease

Due to

Other Conditions Heart Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature S. Palmason M. D.
Address University Hospital Date signed 8-20-44

G20147

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1462

G20147

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto - (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Scott St (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Howard Pfaff

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) August, 7 1877

8. AGE: Years	Months	Days	If less than one day
66	0	19	..... hr. ..... min.

9. Birthplace Balto - Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Self -

FATHER
12. Name Michael Pfaff
13. Birthplace Balto - Md!

MOTHER
14. Maiden Name Annie Meredith
15. Birthplace Balto - Md.

16 (a) Informant Miss Ida Meredith
(b) Address 1126 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem.
Location Frederick Ave.

18 (a) Funeral director Carl L. Hess
(b) Address 715 Light St.

8/22/1944 (b) .....
(Date received by registrar) (Registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1944 at 5:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1944 to Aug. 21 1944, and that I last saw h[illegible] alive on Aug. 21 1944.

Immediate cause of death	Duration
Carcinoma of stomach with metastasis to liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Aug. 17, 1944
Major findings of operation: Same as above
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Carl L. Hess M.D.
Address 715 Light St Date signed 8/22/44

G20148

Spears

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1464

Registered No. G20148

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33 rd
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Ohio (b) County —
(c) City or town Marietta (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME C. Frederick Spears

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 27 - 1873

8. AGE: Years 71 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name George F. Spears
13. Birthplace France

MOTHER 14. Maiden Name Amelia D. Eichelberger
15. Birthplace Pennsylvania

16 (a) Informant Union Memorial Hospital
(b) Address 33rd & Calvert Street

17 (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof Aug 22/44 (month) (day) (year)
(c) Cemetery or crematory Parkersburg, W. Va.
Location —

18 (a) Funeral director F. D. Hilbert & Son
(b) Address 300 Eutaw Place

19 (a) AUG 22 1944 (Date rec'd by Registrar) Huntington W. Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1944, at 10:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1944, to Aug 21 1944, and that I last saw him alive on Aug 21 1944.

Immediate cause of death	Duration
Cardio Respiratory Failure	
Due to ?	
Due to Carcinoma of Stomach	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug 10, 1944

Major findings of operation: Ca of Stomach (Colon)

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature William H. Lippitt M. D.
Address Union Memorial Hosp. Date signed 8/24/44

G20149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G20149 Registered No.

MARGIN RESERVED FOR BINDING. The information should be carefully supplied. Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 7 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1733 Lancaster st (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Adam Kulesza

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1887

8. AGE: Years	Months	Days	If less than one day
45	3	9	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Stevedore Yard
11. Industry or business

FATHER
12. Name Joseph Kulesza
13. Birthplace Poland

MOTHER
14. Maiden Name Katherine Kglata
15. Birthplace Poland

16 (a) Informant Mrs Katherine Kulesza
(b) Address 1733 Lancaster st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Welsh
(b) Address 40 N. Stricker St

AUG 22 1944 (Date received by Registrar) Registrar

VS 160 For Off. Use Only, by Thomas L. Macleod M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-19 1944, at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1944, to 8-19 1944, and that I last saw him alive on 8-19 1944.

Immediate cause of death Pulmonary edema — Duration

Due to Left sided cardiac failure

Due to Hypertensive cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Pulmonary edema; cardiac hypertrophy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron J. Myers M. D.
Address Sinai Hospital Date signed 8-20-44

G20150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20150 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write figures where words are required, except age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fleet St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Bradley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Albert

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-07-1739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Bertha Patterson
(b) Address 924 Pine St.

17 (a) Burial (b) Date thereof 8-25-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary Cem
Location A. A County Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna Ave

19 AUG 22 1944 Huntington Wilson, Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1944, at 12 15 P M

21. I certify that I took charge of the remains described above, held an Autopsy / Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis
Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Aug. 21 1944

G20151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G20151 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 663 Fremont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROLAND P. HICKS

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13

8. AGE: Years	Months	Days	If less than one day
31	3	7	hr. min.

9. Birthplace Balto md.
(Town, county, and state)
10. Usual Occupation Office
11. Industry or business

FATHER
12. Name Unknown.
13. Birthplace

MOTHER
14. Maiden Name Lula Hicks
15. Birthplace Maryland

16 (a) Informant Laura Hill
(b) Address 663 Fremont Street

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Mrs. Katie B. Williams
(b) Address 3223 Schroeder St

19 (a) (b) Registrar

AUG 22 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1944, at 3:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH
Stab wound of heart
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-20-44 at M.
(b) Where did injury occur? In front 7764 W.
(c) Did injury occur at home, on farm, industrial place, in public place? Jumped While at work? No
(d) Means of injury Knife

23. Signature H. L. Williamson M.D.
Asst Medical Examiner.
Date signed 8-20-44

G20152

G20153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G20152

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6524 Rosemont Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6524 Rosemont Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** DOROTHY ELIZABETH MILLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife William North Mille

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1888

8. AGE: Years 55 | Months 11 | Days 6 | If less than one day: hr. min.

9. Birthplace Eastern Shore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ? Holland
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. William N. Miller
(b) Address 6524 Rosemont Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 - - 44 (month) (day) (year)
(c) Cemetery or crematory Ellwood
Location Memphis, Tenn.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Avenue & Broadway

19 (a) AUG 22 1944 (Date received by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1944, at 10.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/25 1939 to 8/20 1944
and that I last saw alive on 8/5 1944

	Duration
Immediate cause of death: Chronic Myocarditis	5 yrs.
Due to Arterial Hypertension	"
Arterio Sclerosis	"
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John W. Machen M.D.
M. D.
Address 63 E. Belvidere Date signed 8/21/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

G20153 B-04257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20153 Registered No. 159

YA-89285

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs. 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Holland (Carrie)

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 5, 1944

8. AGE: Years | Months | Days | If less than one day: 5 hr. 5 min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER
12. Name John Holland
13. Birthplace Virginia

MOTHER
14. Maiden Name Carrie Pugh
15. Birthplace Alabama

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Cremated (b) Date thereof 8-18-44-3Pm.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

AUG 22 1944 Huntington Williams, M.D. Registrar
(Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5, 1944, at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 PM 1944, to 8/5 PM 1944, and that I last saw her alive on 8/5 PM 1944.

Immediate cause of death: Congenital Atelectasis — Duration 2 hrs. 5 min.
Due to
Due to
Other Conditions: Prem & Twinity
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Berry, Jr. M. D.
M. D.
Address Balto City Hosp Date signed 8/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20154 T.C.P.--89290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20154

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs. 50 Min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Rose Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Hewitt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 6, 1944

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 9 hr. 50 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ross Hewitt
13. Birthplace ?

MOTHER
14. Maiden Name Hilda Zeiler
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 8-18-44 3 P.M. (month) (day) (year)
(c) Cemetery or crematory Balto. City Hosp
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

AUG 22 1944 (Date Filed by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1944 19 , at 4:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-6-44 to 8-6-44 and that I last saw h[illegible] alive on 8-6-44

Immediate cause of death: Intra Cranial Hemorrhage — Duration 10 Min.

Due to: Birth Injury

Due to: Prolonged labor

Other Conditions: Primig, Primip

Pneumonia Previa

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H B Penry, Jr. M.D.

Address Balto City Hosp Date signed 8/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1616

G20155
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County BALTO.
(c) City or town ~~Baltimore~~ Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route 14 Middle River
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Stout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 1 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wade Stout
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lazelle Brannon
15. Birthplace North Carolina

16 (a) Informant Mother
(b) Address

17 (a) Buried (b) Date thereof 8-23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director H. F. Bishop
(b) Address 5305 Belair Rd.

19 (a) (b)
(Signature of registrar) Registrar

AUG 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-16 19~~44~~ at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/14 1944 to 8/16 1944 and that I last saw h[illegible] alive on 8/14 19 44

Immediate cause of death: Erythroblastosis fetalis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mathew E Edwards M. D.

Address St Josephs Hospital Date signed 8/14/44

G20156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G20156

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 555 N. Pulaski
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Davis

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1944

8. AGE: Years	Months	Days	If less than one day
			hr. 15 min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY AUG 17 1944

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

No more information was available as patient was seen in the accident room where complete records are kept. John S. Haughton M.D.

(over)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/7 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/7 1944 to 8/7 1944 and that I last saw h[illegible] alive on 8/7 1944.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John S. Haughton M.D.
Address Univ. Hosp. Date signed 8/9/44

G20157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 13 N

G20157 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 319 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 319 N. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie F. McGuirin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30 1883
8. AGE: Years 60 | Months 7 | Days 21 | If less than one day hr. min.
9. Birthplace New York
(Town, county and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Alex McGuirin
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary Ryan
15. Birthplace Maryland

16 (a) Informant Mary E. Farley
(b) Address 319 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director John A. McGann
(b) Address 3000 E. Balto. St.

19 (a) 8-22-1944 (b) Filed by registrar Hunter Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Aug 20 1944 and that I last saw h alive on Aug 17 1944.

Immediate cause of death	Duration
1 Hypertensive cardio-vascular renal disease	3 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alex P. Sokorsky
Address 1939 N. Calvert Date signed 8/31/44

G20158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20158

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Memorial Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Ralphon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. McManus

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If [illegible], give age years

7. Birth date of deceased (mo., day, yr.) May 12-1885

8. AGE: Years	Months	Days	If less than one day
59	3	9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John. M. McManus
13. Birthplace Balto.

MOTHER
14. Maiden Name Elizabeth Linton
15. Birthplace Ireland

16 (a) Informant Anna Schrisky
(b) Address 608 Ralphon. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24-44 (month) (day) (year)
(c) Cemetery or crematory Mem. Gdns.
Location Old Frederick Rd.

18 (a) Funeral director John J. McGraw
(b) Address 3600 E. Balto St.

19 (a) AUG 24 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21 1944, at 9 52 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Featherston M.D. (Medical Examiner.)
Date signed August 21 1944

VS 151

G20159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20159 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth (Kibbie) Kibby

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6, 1881

8. AGE: Years 63 | Months 7 | Days 15 | If less than one day hr. min.

9. Birthplace Elkridge Howard Co Md
(City, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Thomas Kibby
13. Birthplace Wash. D.C.

MOTHER 14. Maiden Name Elizabeth
15. Birthplace Md

16 (a) Informant Ralph Butler
(b) Address 1413 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Balto Co

18 (a) Funeral director A. Howard Eggers
(b) Address 1400 S. Charles St

AUG 22 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1944 at 9:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1944 to Aug 21 1944 and that I last saw h.. alive on Aug 20 1944

Immediate cause of death: Cardiac thrombosis — Duration 3 days

Due to Hypertension — 6 mos

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Howard Eggers M.D.
Address 1400 S. Charles St Date signed 8/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The color or race is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G20160 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1934 E. Lafayette Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 E. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~: Chas. E. Turner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 13, 1877

8. AGE: Years 67 | Months 4 | Days 7 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Philip E. Smick
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Fannie Weymouth
15. Birthplace Va.

16 (a) Informant Mrs. Dorothy McDonnell
(b) Address 1934 E. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Balto. Md.

18 (a) Funeral director C. J. Flannery & Son
(b) Address 1938 E. Lafayette Ave.
Baltimore, Md.

AUG 22 1944
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1944 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7 1944 to Aug 20 1944 and that I last saw him alive on Aug 20 1944

Immediate cause of death Lobar Pneumonia — Duration 14 days

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Auerbach M.D.
Address 2025 E. North Ave. Date signed 8/20/44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 834

G20161
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 Calvert St.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Northway Apts. Cor. Charles & Univ. pkwy
(If rural give location)
(e) Citizen of foreign country? ND (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. [redacted] (Arcada Polk Hutchinson)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Dr. Mahlon Hutchinson

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — ? —

8. AGE: Years Abt. 84 | Months ? | Days ? | If less than one day ____ hr. ____ min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business none

FATHER
12. Name ? ? Cummings
13. Birthplace — ? —

MOTHER
14. Maiden Name Josephine Polk
15. Birthplace — ? —

16 (a) Informant Harry E Karr
(b) Address Fidelity Bldg

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn
Location Woodlawn

18 (a) Funeral director Stewart Mann Co.
(b) Address 1051 Mondawmin Ave

(By) [redacted] for Baltimore, Md.
Registrar

19 (c) AUG 22 1944 (Filed by registrar)

VS-186

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1944, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1 Aug 1944 to 21 Aug 1944 and that I last saw her alive on 21 Aug 1944.

Immediate cause of death Cardiorespiratory Failure 4

Due to Cerebrovascular accident

Due to Hypertensive Vascular Disease

Other Conditions Arteriosclerosis, General

(Include pregnancy within 3 months of death)

Date of operation 0

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Liffitt M. D.
Address Union Memorial Hosp. Date signed 8/24/44

G20162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20162 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 607 Granby
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Granby St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry L Gilchrest

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-1873

8. AGE: Years 71 | Months 6 | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business

FATHER 12. Name John Gilchrest
13. Birthplace Ireland

MOTHER 14. Maiden name Mary McDermott
15. Birthplace Ireland

16 (a) Informant Mrs. John E Seymour
(b) Address 607 Granby St 8-25-44

17 (a) Burial (b) Date thereof (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Geo. A Fahey
(b) Address Fulton & Fayette

19 (a) Filed 8-25-1944 (b) Registrar Huntington Williams, M.D.

VS 144

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1944 at 6 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 1943 to August 1944 and that I last saw h 17 alive on August 21 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 8/21/44
Due to: Hypertensive & Arterio Sclerotic Cardiovascular Disease — 5 yrs
Due to:
Other Conditions Hypochromic Anemia — 1 yr +
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature
Address 3629 Edmondson Ave Date signed 8/22/44 M.D.

G20163

G20163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 N

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write "R" and give town)
(d) Street No. 3611 Labyrinth Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Kaufman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or wife~~ Claire L. Kaufman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4 1889

8. AGE: Years 55 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Cloak Cutting Director

11. Industry or business Dress Mfr. Corp.

12. Name of FATHER Julius Kaufman

13. Birthplace Germany

14. Maiden Name of MOTHER Susan Koch

15. Birthplace Unknown

16 (a) Informant Mrs. Claire L. Kaufman

(b) Address 3611 Labyrinth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/44 (month) (day) (year)

(c) Cemetery or crematory Bath. Hebrew

Location Bath. Md.

18 (a) Funeral director Harold Sonnenborn & Son

(b) Address 1902 Eutaw Pl. Huntington Williams, M.D.

AUG 23 1944 (b) Registrar

Date rec'd by registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-21 1944, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1944 to 8-21 1944.
That I last saw him alive on 8-21 1944.

Immediate cause of death Pulmonary hemorrhage — Duration

Due to Bleeding into pulmonary cavity

Due to Chronic fibrocaseous tuberculosis — Duration 2 months

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Autopsy Chronic fibrocaseous tbc. of both lungs

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J. Lyons M. D.

Address Sinai Hospital Date signed 8-24-44

G20164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G20164 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2220 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2220 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME LILLIE WINTERNITZ COHEN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Eli G. Cohen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11th. 1879.

8. AGE: Years	Months	Days	If less than one day
65	3	10	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Winternitz,
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Sophia Wheatfield,
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Calvin Cohen,
(b) Address 2038 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/44. (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Baltimore, Md.

18 (a) Funeral director Harris Sonnenstein & Son
(b) Address 1902 Eutaw Place.

19 (a) AUG 23 1944 (b) Signature of registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21st. 1944, at 11:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-3-1944 to 8-21-1944 and that I last saw h~~e~~r alive on 8-21-1944.

Immediate cause of death	Duration
Heart failure	
Due to Cachexia	
Due to Cancer of breast	
Other Conditions Metastases to lungs liver peritoneum and brain	

(Include pregnancy within 3 months of death)

Date of operation 6-6-44

Major findings of operation: Cancer of left breast, metastases of axillary glands

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P. Weinberger M. D.
Address 912 Brooks Lane, Date signed

Dr. E H. Meyer
1614 33rd St.

20165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 620165

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2718 Tivoly Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2718 Tivoly Ave (If rural give location)
(e) Citizen of foreign country?: (Yes or No)
If yes, name country

3 (a) FULL NAME Rogers Lee Zentz

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-4566

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lydia L. Zentz
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Sept. 8-1882

8. AGE: Years	Months	Days	If less than one day
61	11	12	hr. min.

9. Birthplace Thurmont, Md. (Town, county, and state)
10. Usual Occupation Milk Salesman
11. Industry or business

FATHER
12. Name Robert D. Zentz
13. Birthplace Thurmont, Md.

MOTHER
14. Maiden Name Sarah Biggs
15. Birthplace Taneytown, Md.

16 (a) Informant Lydia L. Zentz
(b) Address 2718 Tivoly Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 23-44 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Hampstead, Md.

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave

19 (a) AUG 23 1944 Washington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 20 19 44, at 4 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 19 44 to Aug 20 19 44, and that I last saw h alive on Aug 20 19 44

Immediate cause of death	Duration
Metastic Carcinoma	
Due to A Inguinal Lymph	8 mos.
Due to Nodes.	
Other Conditions Rectus polyp. Carcinomatic	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E H Meyer M. D.
Address 150 E 33rd Date signed 8/24/44

C20166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600

Registered No. C20166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure that each item is correct and complete. Physicians: please write the causes of death clearly and legibly. Information as to cause of death is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Bayard Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 14, 1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation -
11. Industry or business -

FATHER
12. Name William Jones
13. Birthplace North Carolina

MOTHER
14. Maiden Name Naomi Jenkins
15. Birthplace Maryland

16 (a) Informant Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL AUG 22 1944.

18 (a) Funeral director Commissioner of Health
(b) Address

AUG 23 1944 (Date filed) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 1944, at 7:12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 14 1944, to Aug. 15 1944, and that I last saw h or alive on August 15 1944.

Immediate cause of death	Duration
Prematurity	
Due to	
Due to Natural Prematurity Separation of Placenta	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philip P. Stapleton, Jr. M. D.
Address Date signed

VS 250

2102

[redacted] G20167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

Registered [redacted] G20167

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 Olive Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas L. West

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

UNIVERSITY MEDICAL SCHOOL AUG 22 1944

18 (a) Funeral director: Commissioner of Health
(b) Address

AUG 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to Fall from high place

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-12-44 at 5.1 M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury fall from 2nd story window

23. Signature H. & D. Clements M.D. Medical Examiner.
Date signed August 14 1944.

2101

G20168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

Registered No. G20168

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.,
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 wks.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ~~Baltimore~~ Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Clarendon Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOPHIA RICHTER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Lorenz Richter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1877

8. AGE: Years	Months	Days	If less than one day
67	4	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Henry Horstman
13. Birthplace Germany

MOTHER
14. Maiden Name Don't know
15. Birthplace Germany

16 (a) Informant Carl G. Schuster
(b) Address 113 Clarendon Ave., 8

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/23/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) (Registrar) AUG 23 1944 (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1944 at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from January 1st 1939 to August 20th 1944, and that I last saw her alive on August 20th 1944.

Immediate cause of death	Duration
Chronic Myocarditis	1yr
Due to Coronary Sclerosis	2yrs.
Due to Art. Sclerosis	5yrs.
Other Conditions Hypertension 5yrs. (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature James A. Miller M.D.
Address Pikesville, Md. Date signed 8/22/44

G20169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G20169 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N. Highland Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Highland Ave.,
(If rural give location)
(e) Citizen of foreign country? 4 (Yes or No)
If yes, name country

3 (a) FULL NAME LEWIS KEENEY

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie A. Keeney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1877

8. AGE: Years 66 | Months 11 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Restaurateur

11. Industry or business

FATHER
12. Name Ezra Keeney
13. Birthplace Maryland

MOTHER
14. Maiden Name Rebecca Young
15. Birthplace Maryland

16 (a) Informant Mrs. Nellie Keeney
(b) Address 22 N. Highland Ave.,

17 (a) Burial (b) Date thereof 8/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

AUG 23 1944 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

P

20. DATE OF DEATH August 21, 1944, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944, to Aug 21 1944, and that I last saw ~~him~~ alive on Aug 21 1944.

Immediate cause of death: Intracranial Hemorrhage — Duration: 1 hr.
Due to: Carcinoma of Rectum — Duration: 1 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. N. Meyer M.D.
Address 1500 E. 33rd Date signed 8/23/44

G20170 G20170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1220 Registered No.

VA-89478

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3548 Roland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Tracey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 24, 1899

8. AGE: Years	Months	Days	If less than one day
45	2	28	hr. min.

9. Birthplace Md.
10. Usual Occupation Housewife (Nature of work, industry, and state)
11. Industry or business

FATHER
12. Name William Martin
13. Birthplace Md.

MOTHER
14. Maiden Name Nora Grimes
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 25 1944 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hampden

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615 - 17 Chestnut Ave

19 (a) (Date signed) AUG 25 1944 (b) Registrar Huntington Witherell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1944, at — M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1944, to 8-22 1944, and that I last saw h. C.R alive on 8-22 1944.

Immediate cause of death	Duration
Pulmonary atelectasis	8 hrs.
Due to Post operative.	
Due to	
Other Conditions Intest obstruction	3 days

(Include pregnancy within 3 months of death)
Date of operation 8-21-44
Major findings of operation: Strangulated hernia
of autopsy: Pul. atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Hauck E. Belton M.D.
Address Balt. City Hosp. Date signed 8/25/44

G20171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20171 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. RESERVED FOR BINDING
Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 N.WASHINGTON ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N.WASHINGTON ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM C.UHLER

3 (b) If veteran, name war: W.W.# 1
3 (c) Social Security Account No.:
4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: ELIZABETH A.UHLER
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) MAR.18 1891
8. AGE: Years 53 | Months 5 | Days 4 | If less than one day hr. min.
9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation GUARD
11. Industry or business GLEN L.MARTINS

FATHER
12. Name JACOB UHLER
13. Birthplace CHES. Chesapeake

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace CHES. Chesapeake

16 (a) Informant ELIZABETH A.UHLER (WIFE)
(b) Address 621 N.WASHINGTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG.25/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Tilly and Zeiler INC
(b) Address 403 S.WOLFE ST.

19 (a) Date received by Local Registrar AUG 23 1944 (b) Registrar
VS 150

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 22 19 44at 9/15 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 44 to Aug. 22 19 44, and that I last saw her alive on Aug. 22 19 44

Immediate cause of death: Coronary Thrombosis — Duration: acute

Due to: Carcinoma of stomach with metastasis — 3-4 mos.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Isaac Steinglass M. D.
Address 2007 E.Fredk Date signed 8/23/44

20172 T.G.P.-39074

J-05201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G20172

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N. Biddle Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Mitchell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-20-44

8. AGE: Years	Months	Days	If less than one day
0	0	16	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Mitchell
13. Birthplace North Carolina

MOTHER
14. Maiden Name Louise Oxendine
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 8-21-44 3PM (month) (day) (year)
(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 (a) AUG 23 1944 (Day of receipt) (b) Huntington Williams, M.D.

VS 1st

MEDICAL CERTIFICATION

A

20. DATE OF DEATH August 6, 1944 19 , at 12:58 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944, to Aug. 6 1944, and that I last saw her alive on Aug. 6 1944

Immediate cause of death Prematurity + pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Not taken

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Kayle M.D.

Address BCH Date signed 8/21/44

G20173 DORAN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944 Registered No. G20173

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1219 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 E. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Magdalena Doran

3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex: Female | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wilbur B.

6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) March 24-1877

8. AGE: Years 67 | Months 66 | Days 4 | If less than one day: hr. min. 27

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Casper Heim
13. Birthplace Germany

MOTHER — 14. Maiden Name Dorothy Knoth
15. Birthplace Germany

16 (a) Informant Wilbur B. Doran
(b) Address 1219 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25-44 (day) (year)
(c) Cemetery or crematory Pt. Peters
Location Balto Co.

18 (a) Funeral director John A. McCann
(b) Address 3008 E. Balto. St.

19 (a) AUG 23 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1944, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 21 1943 to Aug 17 1944, and that I last saw h. alive on Aug 17 1944.

Immediate cause of death	Duration
Coronary Thrombosis	?
Due to Hypertension & Nephritis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Lamm, M.D.
Address 1761 E. Mt. St. Date signed 8/22/44

G20174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-a

Registered No. G20174

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4200 Belvieu Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 85 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Belvieu Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Emily McConn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles B. McConn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1859

8. AGE: Years 85 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Francis H. Holton
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Louise Higgins
15. Birthplace Baltimore Md

16 (a) Informant Ethel L. McConn
(b) Address 4200 Belvieu Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Harry N. Womack
(b) Address 4204 Ridgewood Ave

19 Aug 22 1944 (Date received) Washington Williams, M.D. (Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1944 at 11.00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1944 to Aug 21 1944 and that I last saw h[illegible] alive on Aug 21 1944

Immediate cause of death Uremia & Edema
Cerebral hemorrhage
Hemiplegia

Duration between onset and death: 3 yrs 10 days 6 hours 6 months

Due to Complete fecal retention
Decubitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Otto Hunter Guenell M. D.

Address 2125 Mt. Ver. Date signed 8/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1839

Registered No. G20175

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2517 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2517 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith A. Gaddis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Clifton W. Gaddis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1894

8. AGE: Years	Months	Days	If less than one day
50	3		hr. min.

9. Birthplace Calvert Co., Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Benson Chase
13. Birthplace Calvert Co., Md

MOTHER
14. Maiden Name Unknown
15. Birthplace Calvert Co., Md

16 (a) Informant Clifton W. Gaddis
(b) Address 2517 Madison Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 8-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location Baltimore Maryland

18 (a) Funeral director Archibald G. Gaddis
(b) Address 2101 McCulloh St Balto

19 AUG 23 1944 (Date rec'd by Registrar) (b) Huntington Williamsville, Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21, 1944 at 2:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Aug 21, 1944 and that I last saw h.e alive on Aug 21, 1944.

Immediate cause of death Coronary Thrombosis
Due to High Blood Pressure
Other Conditions
(Include pregnancy within 3 months of death)

Duration
5 hrs.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ray Ellis M. D.
Address 521 Mosh. Ave Signed 8/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G20176

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mo
(e) Length of stay in Baltimore (yrs., mos., or days) Born

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. - 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 Wyeth St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Larry Arthur Flascomb.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1944

8. AGE: Years	Months	Days	If less than one day
	2	25	hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Joseph Flascomb.
13. Birthplace Maryland

MOTHER
14. Maiden Name Edith Benner.
15. Birthplace Maryland.

16 (a) Informant Hosp Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial
Location Governor Ritchie Highway Park

18 (a) Funeral director Ambrose Frie
(b) Address 414 N Franklintown Rd

19 (a) AUG 23 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 19 44 to [illegible] 19 [illegible]
and that I last saw h[illegible] alive on Aug 27 19 44

Immediate cause of death Cardiac Resp Failure — Duration -

Due to Toxic Diarrhea — 3 Days

Due to

Other Conditions Dehydration Acidosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J Welch M. D.
Address Medical Date signed Aug 27 1944

G20177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 15 7y

G20177 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & Collington Ave
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DEACEASED:
(a) State Md (b) County Balto
(c) City or town Balto (If outside city limits, give township)
(d) Street No. Franklin Sq. Hosp (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Liddle {Parents address 705 N. Collington Ave}

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/8/44

8. AGE: Years | Months | Days 14 | If less than one day hr. min.

9. Birthplace Balto.-Md U. S. Hosp. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Kenneth

13. Birthplace

MOTHER 14. Maiden Name Mamie

15. Birthplace

16 (a) Informant Hospital Record

(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/23/44 (month) (day) (year)

(c) Cemetery or crematory Dru Bris Penna.

Location

18 (a) Funeral director Philip Henry Sons

(b) Address 524 Orleans St.

19 (a) AUG 23 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/44 19 , at 1:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8-44 19 to 8-22-44 19 , and that I last saw h[illegible] alive on 8[illegible]44 19 .

Immediate cause of death Peritonitis — Duration

Due to (a)

Due to (b)

Other Conditions Int. obstruction Ileo-colostomy

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: Acute Int. Obstruction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Clyde Webster

Address Franklin Square Hosp Date signed 8/23/44

G20178

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20178 / 940 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1650 Moreland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Runston Avenue (If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Poland

3 (a) FULL NAME Sylvia Bach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 63 | Months | Days | If less than one day: hr. min.

9. Birthplace Warsaw, Poland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin
13. Birthplace Poland

MOTHER
14. Maiden Name Hannah
15. Birthplace Poland

16 (a) Informant Joseph Bach
(b) Address 3402 Avondale Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Lewis
(b) Address 1434 E Baltimore

19 (a) (Date received by Registrar) (b) Huntington Williams, Registrar
AUG 23 1944
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1944, at 1 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed August 23 1944

G20179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1934

G20179 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1819 N. Appleton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1819 N. Appleton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rachel Lurie

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jacob

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 68 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: Russia

MOTHER
14. Maiden Name: ?
15. Birthplace: Russia

16 (a) Informant: Henry Benjamin
(b) Address: 1819 N. Appleton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug 23-1944 (month) (day) (year)
(c) Cemetery or crematory: Rosedale
Location: Workmans Circle Cem.

18 (a) Funeral director: Jack Lewis
(b) Address: 1439 E Baltimore

AUG 23 1944

19 (a) (Date rec'd by registrar) (b) Huntington, W. Va. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1944, at 2:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Hypertensive Cardiovascular Disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: H Lee Millenmeb M.D. Medical Examiner.
Date signed August 23, 1944

G20180 BALTIMORE CITY HEALTH DEPARTMENT G20180
CERTIFICATE OF DEATH 1944 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2104 Westwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2104 Westwood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Nathan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Benjamin
13. Birthplace Russia

MOTHER 14. Maiden Name Esther
15. Birthplace Russia

16 (a) Informant Louis Nathan
(b) Address 2104 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-44 (month) (day) (year)
(c) Cemetery or crematory Cem
Location Rosedale

18 (a) Funeral director Jack Lewis Inc
(b) Address AUG 23 1944 1439 E Balto. St

19 (a) (Date rec'd by registrar) (b) Registrar
Huddington Williams, Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22 1944 at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944 to Aug. 22 1944 and that I last saw him alive on Aug. 22 1944

Immediate cause of death: Edema of Lungs — Duration: 3 Days
Due to: Cortic Insufficiency — 5 yrs
Due to: Cancer
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M J Bayless M.D.
Address 710 Eutaw St Date signed 8/23/44

G20181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 b X G20181 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 E. Main St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ferdinand C Wheeler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Nina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 24th 1879

8. AGE: Years	Months	Days	If less than one day
65	5	28	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Retired executive

11. Industry or business

FATHER
12. Name Ferdinand C. Wheeler
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary Cecelia Battomer
15. Birthplace Balto Md

16 (a) Informant Nina Barr Wheeler
(b) Address 328 E. 42nd St. N.Y. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24th 44 (month) (day) (year)

(c) Cemetery or ~~cemetery~~ New Cathedral
Location Balto Md

18 (a) Funeral director H.W. Jenkins Sons Co
(b) Address 1911 E. Fallsh + Orchard

19 (a) (To be signed by registrar) (b) Registrar

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1944, at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1944 to 8/22 1944 and that I last saw him alive on 8/22 1944

Immediate cause of death Uremia — Duration

Due to Chronic Glomerulo-nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M. D.

Address St. Agnes Date signed

Hosp- 8/22/44

3247 G20182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30d

G20182 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-4
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 14 N Wolfe St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Anna Medvid
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Stanley Medvid
6 (c) If alive, give age P years

7. Birth date of deceased (mo., day, yr.) 10-9-15

8. AGE: Years	Months	Days	If less than one day
28	10	12	..... hr. ..... min.

9. Birthplace Mass. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Michael Ring
13. Birthplace Mass

MOTHER
14. Maiden Name Bridie
15. Birthplace Mass

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 24-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Frank Della Rose
(b) Address 52 W Monroe St

19 (a) AUG 25 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1944 at 2 50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to Aug 21 1944 and that I last saw her alive on Aug 21 1944

Immediate cause of death Ruptured aortic Aneurysm — Duration 2 hr

Due to Subacute Bacterial Endocarditis

Due to Rheumatic Fever

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature H E Cestwright M. D.
Address Johns Hopkins Hospital Signed 8-24-44

Huntington Williams M.D.

G20183 1 of 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20183 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3900 - EIGHTH. ST.
(c) Hospital or institution Brooklyn
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3900 Eighth Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Jonthen Hawkins
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-10-7257

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife Ida Mullen
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
about 65			hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Steam Crane

FATHER
12. Name William Hawkins
13. Birthplace A. A. Co. Md.

MOTHER
14. Maiden Name Hanna Carr
15. Birthplace A. A. Co. Md.

16 (a) Informant Marietta Longest
(b) Address 390[illegible] - 8th Ave

17 (a) [illegible] (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Rielzie Highway

18 (a) Funeral director John J. Raley & Sons
(b) Address 1319 Eight St.

AUG 22 1944 (Delivered to Registrar) (b) Huntington Williamsburg, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 21 1944, at 1630 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944, to Aug 21 1944, and that I last saw h. alive on Aug. 13 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Lutem M. D.
Address 320 Patapsco Ave Date signed 8/24/44

G20184 Cop

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830

G20184 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto. 29
(If outside city or town limits, write RURAL and give town)
(d) Street No. 446 Rosecroft Terrace
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Bernard P. Gately
3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-01-3422

4. Sex: Male
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Mrs. Mary Gately
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 17, 1888
8. AGE: Years 56 | Months 5 | Days 10 | If less than one day — hr. — min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Sales Rep.
11. Industry or business Allied Paper Bag Co.

FATHER
12. Name Thomas Gately
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne McCormick
15. Birthplace Ireland

16 (a) Informant Mrs. Gately
(b) Address 446 Rosecroft Terrace
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Old Greenmount Rd.
18 (a) Funeral director Joseph Light & Sons
(b) Address 1318 Light St.
19 (a) AUG 26 1944 (Date received by registrar) (b) Attesting for Williams

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1944, at 9:15 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1944, to Aug. 22 1944, and that I last saw him alive on Aug. 22 1944.

Immediate cause of death	Duration
Respiratory failure	—
Due to Cerebral hemorrhage	2 hrs.
Due to Hyper tension	10 yrs.
Other Conditions Uremia. Fractured rt. tibia. (Include pregnancy within 3 months of death)	?

Date of operation —
Major findings of operations: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 7-31-44 at — A. M.
(c) Where did injury occur? Mercy Hospital (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? no
(e) Means of injury Slipped & fell to floor
23. Signature Ellsworth Cole Jr. M. D.
Address Mercy Hospital Date signed 8-22-44

G20185 — BALTIMORE CITY HEALTH DEPARTMENT — G20185

CERTIFICATE OF DEATH

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 S. Mount St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 331 S Mount St
(If rural give location)
(e) If foreign born, how long in U. S. A.? 65 yrs years

3 (a) FULL NAME Mary Fitzmaurice
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Unknown 1862

8. AGE: Years	Months	Days	If less than one day
82.			hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation house work
11. Industry or business at home

FATHER
12. Name Michael Fitzmaurice
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen McDonald
15. Birthplace Ireland

16 (a) Informant Mrs Annie Blum
(b) Address 1012 McCulloh St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/'44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road
18 (a) Funeral director John J Conway Son
(b) Address 901-03 Hollins St
19 (a) (Date rec'd by registrar) (b) Registrar

Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22nd, 1944 at 8.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1944 to Aug 22 1944 and that I last saw h alive on Aug 21 1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to —

Due to —

Other Conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Albert Scagnetti M. D.
Address 1729 W Lombard Date signed 8-22-44

G20186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G20186 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4613 PK. HGTS. AVE
(c) Hospital or institution: Mt. SINAI HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town DANVILLE (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES H. HORDISH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Kate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 97 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name

13. Birthplace Poland

MOTHER 14. Maiden Name

15. Birthplace Poland

16 (a) Informant Anna Silverman

(b) Address 753 YANK St, DANVILLE Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-23-44 (month) (day) (year)

(c) Cemetery or crematory Danville, Va.

Location

18 (a) Funeral director Jack Lewis Inc

(b) Address 1439 E. Balto. St

AUG 23 1944 (Date received by Registrar) Huntington Willis (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23-44 19 , at 11 45 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 19 44 to 8/23 19 44.
and that I last saw him alive on 8/23 19 44

Immediate cause of death: Acute Cerebral Hemorrhage — Duration

Due to

Due to Ch Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. L. Hamilton M.D.

Address 733 Arnett St Date signed 8/23/44

VS 150

G20187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49W

G20187 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2045 Wheeler Ave
(c) Hospital or institution: 1544
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2045 Wheeler Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Mezwensky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER: 12. Name Aaron Beller
13. Birthplace Russia

MOTHER: 14. Maiden Name Rose ?
15. Birthplace Russia

16 (a) Informant Benjamin Mezwensky
(b) Address 2045 Wheeler Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug, 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel Cem
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 N. North Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

AUG 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1944, at 10:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Past year to Aug 23 1944, and that I last saw h-er alive on Aug 22 1944.

Immediate cause of death Pneumonia

Due to Carcinomatosis

Due to Malignancy ovary.

Other Conditions Ascites.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. E. Needle

Address 2314 - 002 North Th Date signed 8/23/44

G20188
458650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20188
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Prince.
(c) City or town Dundalk, BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 6718 Holabird (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Wyspinski

3 (b) If veteran, name war

3 (c) Social Security Account No. 198-14-1412

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-18-21

8. AGE: Years	Months	Days	If less than one day
22	10	4	hr. min.

9. Birthplace Minn. (Town, county, and state)
10. Usual Occupation Air Craft
11. Industry or business

FATHER
12. Name Earl Wyspinski
13. Birthplace Minn.

MOTHER
14. Maiden Name Hilda Hitzemann
15. Birthplace Minn.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/44 (month) (day) (year)
(c) Cemetery or crematory
Location Scranton, Pa.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address Balto. Md.

19 (a) Huntington Williams M.D. (By registrar) Registrar

DC 23944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1944, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 4 1944, to Aug 22 1944, and that I last saw him alive on Aug 22 1944.

Immediate cause of death	Duration
Pericarditis	14 yr
Due to Tuberculosis	
Due to (or)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Cartwright M. D.
Address Johns Hopkins Date signed 8-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

G20189

CERTIFICATE OF DEATH 1944

G20189 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 East 20th, Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 East 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John Joseph Tillman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice P. Tillman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1876

8. AGE: Years 68 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Auditor

11. Industry or business: Archer Laundray

FATHER
12. Name: Nicholas Tillman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Matilida Storck
15. Birthplace: Germany

16 (a) Informant: Francis Neal Tillman
(b) Address: 2536 Liberty Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer Cem.
Location

18 (a) Funeral director: Mary M. Wiederold
(b) Address: 501 East 22nd Street

19 (a) Date filed by registrar: AUG 23 1944 (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21/44 19 ... at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 40 to Aug 21, 19 44 and that I last saw h... alive on Aug. 21/19 44.

	Duration
Immediate cause of death: Myocardial Insufficiency	4 days
Due to: Pulmonary Tuberculosis	7 yrs
Due to: Arteriosclerosis	7 yrs
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Thomas F. Mette M. D.
Address: 537 E. 22nd St Date signed 8/22/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G20190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 S. Hanover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward James Catlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband or~~ wife Cora V. Nicholas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1899

8. AGE: Years 45 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace W Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Arthur Catlett
13. Birthplace W. Va.

MOTHER
14. Maiden Name Ella Virginia Statler
15. Birthplace W Va

16 (a) Informant Mrs. Ethel Lucas
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Fairlight Gdns
Location Fairlight, W. Va.

18 (a) Funeral director E. C. Higgins Bathurst
(b) Address Ellicott City, Md.

19 AUG 24 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1944, at 4:15 P.M.

21. I certify that I took charge of the remains described above, held an partial autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning. Probably accidental

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-22-44 at 4:30A. M. 4-1
(b) Where did injury occur? Foot of Pier 4 - Bratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Drowned in Harbor.

23. Signature H. Williams M.D. Medical Examiner.
Date signed August 23, 1944.

(Over)

G20191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22W

Registered No. G20191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1311 Orleans St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) Country
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1311 Orleans St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Lee Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. 220-12-9020

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12-1926

8. AGE: Years	Months	Days	If less than one day
18	1	9	hr. min.

9. Birthplace Baltimore City
(Town, county, and state)
10. Usual Occupation Soldier
11. Industry or business

FATHER 12. Name Archie Smith
13. Birthplace Somerset Co. Md.

MOTHER 14. Maiden Name Birtha Edwards
15. Birthplace Marleyfield A.A. Co. Md.

16 (a) Informant Birtha Smith
(b) Address 1311 Orleans St.

17 (a) Burial (b) Date thereof Aug 26-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Marleyfield
Location A.A. Co. Md.

18 (a) Funeral director Robert E. Williams
(b) Address 1515 McElderry St.

19 AUG 24 1944 (b) Huntingtown Md. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1944 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 25 1944 to Aug 20 1944. and that I last saw deceased alive on 8-20 1944

Immediate cause of death	Duration
Acute Miliary T.B.	2 Mos
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Calvin B. LeCompte M. D.
Address 1113 N Carlin St Date signed 8/23/44

G20192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G20192

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Olivia & Caroline Sts
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4304 Furley ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo Benjamin Pitcher

3 (b) If veteran, name war — 3 (c) Social Security Account No. 213-12-8844

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1874

8. AGE: Years	Months	Days	If less than one day
70	1	25	hr. min.

9. Birthplace Calvert County, Md
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John Thomas Pitcher
13. Birthplace Liverpool, England

MOTHER
14. Maiden Name Martha A. Kershaw
15. Birthplace

16 (a) Informant Rev. John W. Pitcher
(b) Address 4304 Furley ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory Water's Memorial
Location Island Creek, Md

18 (a) Funeral director Howard N. Bligh Jr.
(b) Address 4914 Belair Road

AUG 24 1944 (b) Huntington Williams MD
(Registered Health Officer) (Date Received) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1944 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1944 to 8/22 1944, and that I last saw h. alive on 8/22 1944.

Immediate cause of death
Cardiac Failure
Due to Pneumonia
Due to (or)
Other Conditions Arteriosclerosis
(Include pregnancy within 3 months of death)

Duration

Date of operation —
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Nathan D. Lamden
Address St. Joseph Hospital Date signed 8/22/44 M.D.
Nathan D. Jaworski

G20193 Wiest

BALTIMORE CITY HEALTH DEPARTMENT X 61

CERTIFICATE OF DEATH

Registered No. G20193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 819 Braeside Road

(c) Hospital or institution: Church Home & Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days

(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 819 Braeside Road (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ethel L. Wiest

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Augustine S. Wiest

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 29 1889

8. AGE: Years 55 | Months 4 | Days 23 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Nurse

11. Industry or business

FATHER 12. Name Thos Mumma

13. Birthplace Maryland

MOTHER 14. Maiden Name Ida Bangin

15. Birthplace Maryland

16 (a) Informant Augustine S. Wiest

(b) Address 819 Braeside Rd.

17 (a) Burial (b) Date thereof 8/26/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Meadow Ridge

Location Dorsey Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

AUG 24 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-22-1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-10 1944 to 8-22 1944 and that I last saw h[illegible] alive on 8-22-1944

Immediate cause of death: Coronary infarction — Duration: Sudden

Due to: Arteriosclerotic heart disease

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Dwight Diehl M. D.

Address Church Home & Hosp. Date signed 8-24-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20194

BARTSCHER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G20194 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5307 Wendley Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Bartscher

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of ~~husband or~~ wife: Mary V. Bartscher
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 10 1878
8. AGE: Years 66 | Months 1 | Days 12 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Collector
11. Industry or business Kracht Bros

FATHER
12. Name George Bartscher
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary C. Hall
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Mary Bartscher
(b) Address 5307 Wendley Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Md.
Location

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Paul St.

19 AUG 24 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1944, at 11 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1944, to Aug 22 1944, and that I last saw him alive on Aug 22 1944.

Immediate cause of death: Myocardial failure — Duration

Due to: Hypertensive cardiovascular disease

Due to:

Other Conditions: Uremia Benign prostatic hypertrophy

Operation (including pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Fillow M. D.
Address Sinai Hospital Date signed 8/25/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157a

Registered No. G20195

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1517 Pentridge Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Warren Wells Bortner JR

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed, or divorced~~
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 22nd 1944

8. AGE: Years	Months	Days	If less than one day
	5 mos	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Warren W Bortner Sr
13. Birthplace Baltimore

MOTHER
14. Maiden Name Doris Dow
15. Birthplace Massachusetts

16 (a) Informant Roland L. Bortner
(b) Address 4410 Wickford Rd

17 (a) Burial (b) Date thereof 8/24/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St.

AUG 24 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1944 at 10:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Aug 23 19..., and that I last saw him alive on Aug 22 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Increased intracranial pressure	
Due to Encephalogram Air in ventricles	
Other Conditions Hydrocephalus	5 mos

(Include pregnancy within 3 months of death)
Date of operation 8-23-44
Major findings of operation:
of autopsy: Hydrocephalus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Thompson Jr. M. D.
Address 332 E. University Pkwy Date signed 8/23/44

G20196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √41a

Registered No. G20196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1347 S. Clinton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles S. Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-12-5212

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife Josephine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th 1877

8. AGE: Years 67 | Months 6 | Days 7 | If less than one day hr. min.

9. Birthplace Crisfield Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Baugh Fertilizer Co.

FATHER
12. Name (Unknown) Morgan
13. Birthplace "

MOTHER
14. Maiden Name Elizabeth Morgan
15. Birthplace Md.

16 (a) Informant Mrs Josephine Morgan
(b) Address 1347 S. Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Mt. Carmel
Location Balto. Md

18 (a) Funeral director William Cook Inc.
(b) Address 1217 E. Pratt St

19 (a) AUG 24 1944 (b) Huntington Williams, M.D.
(Registered by) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1944, at 12 55 M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest and from the evidence obtained thereon
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Larynx

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Charles S. Sullivan M.D.
Medical Examiner.
Date signed 8/22/44

G20197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20197 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the word "None" where it is applicable. Do not leave any blank unless directed to do so. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene Sts
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore 30 Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 782 Carroll St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Shriver

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 13 1882

8. AGE: Years	Months	Days	If less than one day
62	6	8	— hr. — min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Neck tie cutter

11. Industry or business Artistic Needlewear Co.

FATHER
12. Name Ralph Shriver
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary Zimmerman
15. Birthplace Md.

16 (a) Informant Self
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Date received AUG 24 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/21 1944 at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1944, to 8/21 1944, and that I last saw h.IM alive on 8/21 1944

Immediate cause of death
(a) Resp. & Cardiac Failure — Duration 12 hrs.
Due to (b) Coronary Thrombosis — 36 hrs.
Due to (c) —
Other Conditions Pulmonary edema — 24 hrs.
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

PHYSICIAN
Underline the cause to which death should be charged statistically.

23. Signature Alfred T. Nelson M.D.
Address University Hospital Date signed 8/21

G20198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20198 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33[illegible] + Calvert
(c) Hospital or institution U.M.H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5793 Clear Spring Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. VIRTIE HAMMER

3 (b) If veteran, name war: —
3 (c) Social Security Account No. 21826

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 Aug 1883

8. AGE: Years 61 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county, and state)

10. Usual Occupation Housf.

11. Industry or business

FATHER
12. Name Samuel Parks
13. Birthplace West Va.

MOTHER
14. Maiden Name La Feure
15. Birthplace West Va.

16 (a) Informant Mr. Harry Hammer
(b) Address 5798 Clear Spring Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/24/44 (month) (day) (year)
(c) Cemetery ~~crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Coots Inc
(b) Address 1217 St. Paul St

19 AUG 24 1944 (Date received) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Aug 1944, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 Aug 1944 to 22 Aug 1944, and that I last saw h[illegible] alive on 22 Aug 1944

Immediate cause of death Cardio-Respiratory

Due to cerebrovascular accident

Due to Hypertensive cardiovascular disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Neal C. Andrews. M. D.

Address Union Memorial Hosp signed 8/25/44
Baltimore, 18, Md.

G20199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 971d

Registered No. G20199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 46

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 735 Mc Henry Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard (Barney) Mignot

3 (b) If veteran, name war no

3 (c) Social Security Account No. 218-01-5387

4. Sex Male | **5. Color or race** White | **6 (a) Single, married, widowed, or divorced.** Married

6 (b) Name of husband or wife Bessie M. Mignot

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1884

8. AGE: Years 59 | Months 8 | Days 0 29 | If less than one day ____ hr. ____ min.

9. Birthplace Belgium (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Bessie M. Mignot
(b) Address 735 Mc. Henry St

17 (a) Burial (Burial, cremation, or removal) **(b) Date thereof** Aug 26, 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director Mr. Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) AUG 24 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to Real death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Glomerulonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. R. Wollenweber M.D. Medical Examiner.
Date signed August 25, 1944.

G20200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d

G20200 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible]
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James M. Ferdon (FERDON)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lillie Fer Don

6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Oct. 29, 1870

8. AGE: Years 73 | Months 9 10 | Days 8 23 | If less than one day ..... hr. ..... min.

9. Birthplace Del.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Medicine

FATHER
12. Name Henry C. Fer Don
13. Birthplace Del.

MOTHER
14. Maiden Name Melissa Murphy
15. Birthplace Del

16 (a) Informant Monroe A. Fer Don
(b) Address 1521 Philadelphia Drive

17 (a) Cremation (b) Date thereof Aug 23 44
(Burial, cremation, or removal)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave

19 (a) [illegible] (b)
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1944, at 11 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerosis
cardiovascular
disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed August 25, 1944.

VS 151

G20201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 109

Registered No. G20201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly. MARGINS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1005 South Kenwood AVe.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1005 South Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Jordan

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife August - Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/18/58

8. AGE: Years	Months	Days	If less than one day
86	6	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Foster
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anna Kaizer
15. Birthplace

16 (a) Informant Margaret Yeager
(b) Address 958 N. Washington ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/44 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location O'Donnell Street.

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

AUG 24 1944 (a) (Local registrar) (b) Huntington Williams M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1944 to 8/22 1944 and that I last saw h[illegible] alive on 8/22 1944

Immediate cause of death (a) Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Matthew J. Mumford M. D.
Address 1076 S. East Ave. Date signed 8/24/44

G20202

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20202
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days) 3 d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Chesapeake Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gross

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Basil

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 22 1879

8. AGE: Years	Months	Days	If less than one day
65	5	0	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Jimmie Hall
13. Birthplace Md

MOTHER
14. Maiden Name Milly Herbert
15. Birthplace Md

16 (a) Informant Nellie Hilbert
(b) Address 1606 Madison Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Calvert Co. Md.

18 (a) Funeral director Wm. Geo H. Holland
(b) Address 1629 Druid Hill Ave

19 (a) AUG 24 1944 (b)
Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/22/44 19 , at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1944 to 8/22 19 44 and that I last saw her alive on 8/22/1944

Immediate cause of death Toxemia

Due to Carcinoma of sigmoid

Due to

Other Conditions

(Include pregnancy within three months of death)

Date of operation August 21, 1944

Major findings of operation: Carcinoma of sigmoid

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H Leuther
Address Mercy Hosp Date signed 8/23/44

G20203

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

G20203 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 Upnor Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Upnor Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Helen F. Trimble

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14 1883

8. AGE: Years 61 | Months 6 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert M. Trimble
13. Birthplace New York N.Y.

MOTHER
14. Maiden Name Margaret A. Mather
15. Birthplace New York N.Y.

16 (a) Informant Mrs. L.D. Miller
(b) Address 211 Upnor Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

AUG 24 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1944, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21 1944 to 8-22 1944, and that I last saw h alive on 8-22 1944

Immediate cause of death Cerebral Hemorrhage — Duration 30 hrs

Due to Hypertensive Cardio-Vasc disease (Past 2 yrs under my care) — 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lester E. Little M.D.
Address 10 W. Madison St. Date signed 8/23/44

G20204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20204 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4620 Elsrode Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4620 Elsrode Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME William Riley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5-1866

8. AGE: Years 77 Months 11 Days 17 If less than one day hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER 12. Name Columbus Riley

13. Birthplace ?

MOTHER 14. Maiden Name Martha ?

15. Birthplace ?

16 (a) Informant Mrs. Edna Lever

(b) Address 4629 Elsrode Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-44 (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director Leonard J. Luck

(b) Address 5309 Harford Road

19 (a) (b) Huntington Williams, M.D.

(Filed by registrar) AUG 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20 1944 to 8-22 1944 and that I last saw him alive on 8-22 1944

Immediate cause of death: Myocardial Insufficiency — Duration 12 hours

Due to: myocarditis — 6 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

(f) Signature Thomas J. Huntington Williams M.D.

Address 5302 E. 22nd St. Date signed 8-24-44

G20205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 17

G20205 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Queen
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Woodwood Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George O. Hansen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married.

6 (b) Name of ~~husband~~ wife Cecelia

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) 8-21-1884

8. AGE: Years	Months	Days	If less than one day
60	7	24	hr. min.

9. Birthplace Md. (town, county, and state)
10. Usual Occupation Fireman
11. Industry or business

FATHER 12. Name Olives Hansen
13. Birthplace Norway

MOTHER 14. Maiden Name Emily Hutton
15. Birthplace Md.

16 (a) Informant Hosp. records.
(b) Address

17 (a) Burial (b) Date thereof 8-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto.

18 (a) Funeral director Leonard J. Hyde
(b) Address 2205 Harford Rd

19 AUG 24 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-23- 1944 at 8:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5 1944 to 8-23 1944 and that I last saw him alive on 8-22 1944

Immediate cause of death Pulmonary Embolism

	Duration
Due to Thrombophlebitis	
Due to Thrombosis - Gangrenous appendicitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 8-5-44
Major findings of operation: Thrombosis Gangrenous appendix
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Hisley M.D.
Address Univ. Hosp. Date signed 8-23-44

G20206 NERTNEY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20206

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Greenmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary A Nertney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife John T. | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1875

8. AGE: Years 69 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER 12. Name Patrick Callaham
13. Birthplace Ireland

MOTHER 14. Maiden Name Johana Ryan
15. Birthplace Ireland

16 (a) Informant Marie Maynadier
(b) Address 3909 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 25/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road

18 (a) Funeral director John A Moran
(b) Address 3000 E Baltimore St

19. Filed AUG 24 1944 (Date received by local registrar) (b) Huntington Williamsport Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1944; at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/18 1944 to 8/21 1944, and that I last saw her alive on 8/21 1944

Immediate cause of death Coronary occlusion — Duration 3 days.
Due to —
Due to —
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Willis Grayston M. D.
Address 3763 Greenmount Ave. Date signed 8/22/44

VS 150

G20207
458894

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

X 61

G20207
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State..... (b) County.....
(c) City or town Washington D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4536 - 26th N.W.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Agnes S Tavina

3 (b) If veteran, name war..... | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-1-75

8. AGE: Years	Months	Days	If less than one day
68	11	23	..... hr. ..... min.

9. Birthplace D.C.
(Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Andrew Stapper
13. Birthplace Germany.

MOTHER
14. Maiden Name Cecelia Ehrenwith
15. Birthplace Md.

16 (a) Informant Rezenda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 8-24-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory.....
Location Washington D.C.

18 (a) Funeral director Francis J Collins
(b) Address 3821-14th St. N.W. Washington D.C.

19 (a)..... (b) Huntington Williams
(Signature of registrar)

AUG 24 1944

MEDICAL CERTIFICATION A

20. DATE OF DEATH Aug-24 1944, at 3.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-9-1944, to Aug-24 1944, and that I last saw h[illegible] alive on Aug-24 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic Renal Disease	
Due to Arteriosclerosis, generalized	
Other Conditions Diabetes Mellitus, Hypertension, Uremia	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Wm. S. Sprunt M.D.
Address Johns Hopkins Hospital Date signed 8-24-44

G20208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a

Registered No. G20208

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 Rosslyn Ave (Is location rural or urban?)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Symes ~~Eves~~ Eves

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	2		hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert DeHart ~~Eves~~ Eves
13. Birthplace Hoadville, Tenn.

MOTHER
14. Maiden Name Ann Elizabeth Boylan
15. Birthplace Baltimore, Md.

16 (a) Informant Robert D. ~~Eves~~ Eves
(b) Address 2212 Rosslyn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-26-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director Edelmann & Pennant
(b) Address 3911 Liberty Heights
(c) Huntington Williams Jr. Registrar
AUG 24 1944 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1944, at 4:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to bed clothes

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15/8
(a) Date of injury August 23, 1944 9:30 P.M.
(b) Where did injury occur? 2212 Rosslyn Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Suffocation by bedclothes

23. Signature Robert Lee Fratcher M.D. Medical Examiner
Date signed Aug. 24 1944

(over)

WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

181

G20209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1 18a

G20209 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Texas (Cockeysville R.D.) (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Richard Ayers

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 212,05,5618

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Agatha (nee Lacey)
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
40	3	1	hr. min.

9. Birthplace: North Carolina (Town, county, and state)
10. Usual Occupation: Electrician
11. Industry or business: Cons. Gas. Elect. Light & Pwr.

FATHER
12. Name: William B. Ayers
13. Birthplace: North Carolina

MOTHER
14. Maiden Name: Leola Freeman
15. Birthplace: North Carolina

16 (a) Informant: Mrs. W. R. Ayers
(b) Address: Route 1, Cockeysville.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-44 (month) (day) (year)
(c) Cemetery or crematory: Poplaw
Location: Cockeysville

18 (a) Funeral director: Lawson M. Burke
(b) Address: Sparks, Md.

19 (a) AUG 24 1944 (Date rec'd by registrar) (b) Filed by Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1944, at 1 02 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Multiple Fractures of back

Due to

Other Conditions /

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 24 1944 1:30 A.M. (15-4)
(b) Where did injury occur? North Cons. Power.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? yes
(d) Means of injury Fall

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed August 24, 1944

G20210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20210
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 823 W. Fayette
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 823 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vicki Kay Villers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12 - 1944

8. AGE: Years | Months 1 | Days 13 | If less than one day hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Jamez B. Villers
13. Birthplace Tulsa Okla.
14. Maiden Name Dotson
15. Birthplace Chattanooga Tenn

16 (a) Informant James B. Villers
(b) Address 823 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Russo Stoney Lodge, Md. Co.
Location

18 (a) Funeral director John A. Zebley Funeral Home
(b) Address 823 S. Paca St

24 1944 (Date filed by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1944 at 8.9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to Aug 20 1944, and that I last saw her alive on Aug 20 1944.

Immediate cause of death	Duration
Premature Birth	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Glassman M. D.
Address 2687 Woodbourne Ave Date signed Aug 24 1944

G20211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X1194 Registered No. G20211

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Sterrson
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Groves

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Groves
13. Birthplace

MOTHER
14. Maiden Name Edith Wolfe
15. Birthplace W. Va.

16 (a) Informant Mother
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 24 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 24 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20 1944, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Aug 20 1944, and that I last saw him alive on Aug 20 1944.

Immediate cause of death	Duration
Dehydration	
Uncontrollable	
Due to Expectoration	
Diarrhea	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Ramsey M. D.
Address [illegible] Date signed 8-23

VS 150

2105

G20212 B-03636 BALTIMORE CITY HEALTH DEPARTMENT G20212

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 332 E Calvert St
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 2mos, 11days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 139 E. Oxford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Margaret Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11 1944

8. AGE: Years | Months: 2 | Days: 11 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lawrence E Brown
13. Birthplace W. Virginia

MOTHER
14. Maiden Name Marie Kane
15. Birthplace Pennsylvania

16 (a) Informant Lawrence E. Brown
(b) Address 139 E Oxford St

17 (a) (Burial, cremation, or removal) (b) Date thereof 8 24 44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Hy. Md

18 (a) Funeral director J J Raley & Sons
(b) Address 847 Light St

19 (a) (Date rec'd by registrar) AUG 24 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1944 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 14 1944 to Aug 23 1944 and that I last saw h[illegible] alive on Aug 23 1944

Immediate cause of death Respiratory failure — Duration

Due to Transfusion reaction

Due to Diarrhea — 3 wks

Other Conditions Premature

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. L. Kingsbury Jr. M. D.
Address 332 E. University Pkwy Date signed 8/24/44

G20213 G20213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57 N

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2000 East Madison St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J Jones Sr.

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-03-8505

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Adelaide Jones
6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) Dec 13, 1877

8. AGE: Years	Months	Days	If less than one day
66 67	8	10	hr. min.

9. Birthplace Baltimore (town, county or state)
10. Usual Occupation Shipping Clerk
11. Industry or business

FATHER
12. Name Oliver H. Jones.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Molly H. Chaffiach
15. Birthplace Baltimore

16 (a) Informant William J. Jones Jr.
(b) Address 2000 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director S. Walter May.
(b) Address 619 N. Bouldin St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1944, at 1.10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944, to Aug 23 1944, and that I last saw him alive on Aug 23 1944.

Immediate cause of death: Carcinoma of the bladder

	Duration
Due to	2 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Cystoscopy revealed tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Sinai Hosp Date signed 8/26/44

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibl

G20214

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and legibly. Physicians: please write correct age in especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20214 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3300 Liberty Heights Ave
(c) Hospital or institution: 15-11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3300 Liberty Heights Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter F. Hidey

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1875

8. AGE: Years	Months	Days	If less than one day
69	3	10	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Contractor & Builder
11. Industry or business Self

MOTHER / FATHER
12. Name August Hidey
13. Birthplace Baltimore Co., Md.
14. Maiden Name Mary Bread
15. Birthplace Baltimore Co., Md.

16 (a) Informant Mrs. Elizabeth E. Hidey
(b) Address 3300 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

AUG 24 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 22 1944, at 4:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 40 to Aug 22 19 44, and that I last saw h[illegible] alive on Aug 22 44.

Immediate cause of death — Duration
Uremia — 7 days
Due to Chronic Nephrosclerosis — 6 mos
Due to arteriosclerosis — 6 mos
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Everett L. Masters M.D.
Address 2 E. of Paul St Date signed 8/23/44

G20215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G20215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age in years, months, days, hours, minutes. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 12 W. FORT AVE
(c) Hospital or institution: 23

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 W. FORT AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin S. Dugger

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20 - 1863

8. AGE: Years 81 | Months 2 | Days 24 | If less than one day hr. min.

9. Birthplace W. VA.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER

12. Name Unknown - Dugger

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Thomas Dugger

(b) Address 12 W. Fort Ave.

17 (a) Transit (Burial, cremation, or removal) (b) Date thereof 8/26/44 (month) (day) (year)

(c) Cemetery or crematory Whitmer Comm.

Location Whitmer W. VA.

18 (a) Funeral director Wm Cole Inc.

(b) Address 1217 Pa Ave

AUG 24 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1944 to Aug 24 1944 and that I last saw h[illegible] alive on Aug 24 1944

Immediate cause of death: Exhaustion — Duration: 3 Dys.

Due to: Arteriosclerosis — Duration: Indef.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R & L Campbell M.D.

Address 1646 Hanover St Date signed 8/26/44

G20216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G20216 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D O A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3055 Strickland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August Mossberger

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-4819

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
M	W	Married

6 (b) Name of ~~husband or~~ wife Elizabeth A. Mossberger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30 - 1880

8. AGE: Years	Months	Days	If less than one day
64	3	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Hillberger Co

FATHER
12. Name John Mossberger
13. Birthplace Germany.

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Mrs. Elizabeth Mossberger
(b) Address 3055 Strickland St

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 8/26/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

AUG 24 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Angina Pectoris

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Aug. 24, 1944

VS 151

G20217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

Registered No. G20217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3319 Parklawn Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Parklawn ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion V. Britler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or divorced: Widowed

6 (b) Name of husband: Harry S. Britler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, y: April 21st 1867

8. AGE: Years 77 | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business: Self

FATHER
12. Name: David Frederick
13. Birthplace: Md.

MOTHER
14. Maiden Name: Elizabeth Frizell
15. Birthplace: Md.

16 (a) Informant: Mrs Harry Primrose
(b) Address: 3319 Parklawn Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/25/44 (month) (day) (year)
(c) Cemetery or crematory: Balto.
Location: " Md

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st

AUG 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23rd 1944, at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22-44, to 8-23-1944 and that I last saw h alive on Aug 22 1944

Immediate cause of death: Hypertensive

Due to: Cardio Vascular Renal

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 1 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: [illegible] M.D.

Address: 60 W Biddle St Date signed: 8-25-44

G20218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G20218 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4513 Bayonne Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-1
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4513 Bayonne Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** EMMA T. CONRAD

3 (b) If veteran, name war: *

3 (c) Social Security Account No.: **

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Widowed

6 (b) Name of husband or wife Otto W.H.Conrad
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	2	hr. min.

9. Birthplace Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gustav Schatzneider
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. John W. Conrad
(b) Address 4513 Bayonne Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Baltimore, Md.

18 (a) Funeral director Lynch & Lynch Funeral Home
(b) Address 7401 Belair Road

19 (a) Filed Huntington Williams (Registrar)
(b) Date received AUG 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23rd, 1944, at 2:07 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 29 1937, to Aug 23 1944, and that I last saw h.. alive on Aug 23 1944.

Immediate cause of death Myocarditis
Cancer of Stomach and Liver
Due to
Due to
Other Conditions Diabetes
Chronic Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 1933 1937

1937 1937

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lachman M. D.
Address 4938 Belair Rd Date signed Aug 24 1944

G20219 G20219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4328 Glenmore Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4328 Glenmore Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINNIE ESPOSITE

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Anton Esposite
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1867

8. AGE: Years	Months	Days	If less than one day
77	0	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Ruckel
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie ----
15. Birthplace Unknown

16 (a) Informant Mr. Anton Esposite
(b) Address 4328 Glenmore Ave.

17 (a) burial (b) Date thereof Aug. 26, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Balto., Md.

18 (a) Funeral director Lansdale Funeral Home
(b) Address 7401 Belair Road

19 (a) [illegible] (Huntington Williams M.D. Registered)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23rd 1944, at 8:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 1944 to 8/23 1944 and that I last saw h[illegible] alive on 8/17 1944

Immediate cause of death Myocardial Degeneration — Duration Unknown
Due to Arteriosclerosis — "
Due to Senility — —
Other Conditions Possible Cancer of Colon — —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John A Macken M. D.
Address 6[illegible] Belair Rd Date signed 8/24/44

VS 150

20220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

127 B

Registered No. G20220

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rebecca & Payson Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 20-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and the town)
(d) Street No. 115 S. Payson Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME VERNA MARIE Schultheis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1929

8. AGE: Years	Months	Days	If less than one day: hr.	min.
15	—	14		

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Waitress

11. Industry or business Stewart & Company

FATHER
12. Name John Schultheis
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Erma M. Wright
15. Birthplace Balto. Md.

16 (a) Informant Mrs. John Schultheis
(b) Address 115 S. Payson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 25-1944 (month) (day) (year)

(c) Cemetery or crematory Western
Location Baltimore, Md.

18 (a) Funeral director George W. Schwab
(b) Address 2101 Frederick Avenue

AUG 25 1944 (Date received by Registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1944, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1944, to 8/24 1944, and that I last saw her alive on 8-24 1944.

Immediate cause of death Generalized Peritonitis — Duration

Due to Intestinal Obstruction

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-19-44

Major findings of operation: Gangrenous loop of small intestine bound by adhesions at autopsy to stump of appendix.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leith W Baldwin M. D.

Address West Baltimore General Hospital Date signed 8/24/44

G20221

AB-70530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20221

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Physicians: please write the causes of death clearly and legibly. Underlining the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2- 8- & 10

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

-2 (d) Street No. 2127 W. Fairmount Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Florence Guntrum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Henry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 25-1893

8. AGE: Years 51 | Months 3 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name George Spedden (D)

13. Birthplace Md.

MOTHER 14. Maiden Name Louise Frantz (D)

15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals-Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 26 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore, Maryland

18 (a) Funeral director George L. Schwab

(b) Address 2101 Frederick Avenue

19 AUG 25 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23- 1944, at 5.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1943 to 8-23 1944, and that I last saw her alive on 8-23-1944

Duration

Immediate cause of death Thrombosis of basilar artery

Due to Cerebrosclerosis

Due to ASCVD

Other Conditions Pseudobulbar Palsy. Hypertensive Cardiac Decompensation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. L. Seigman M.D.

Address 13 CH Date signed 8-25

G20222 F

307133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 1220 Registered No. G20222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2nd Yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County BALTO.
(c) City or town Turners Station (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 Fleming Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lumpkin

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2-12-1918

8. AGE: Years 26 | Months 6 | Days 11 | If less than one day: hr. min.

9. Birthplace Manboro S.C. (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

MOTHER / FATHER

12. Name Willie Lumpkins

13. Birthplace S.C.

14. Maiden Name Ella Adger

15. Birthplace S.C.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof 8-26-44 (month) (day) (year)

(c) Cemetery or crematory Adgers Cemetery

Location Manboro S.C.

18 (a) Funeral director William A Jackson

(b) Address 916 Preston ave

AUG 25 1944 (Date rec'd by registrar) Funeral for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23 1944 at 12 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1944, to Aug 23 1944, and that I last saw h[illegible] alive on Aug 23 1944

Immediate cause of death: Respiratory & cardiac Failure during

Due to: ? anesthesia — Duration:

Due to: —

Other Conditions: Strangulated Inguinal hernia - left — 2d

(Include pregnancy within 3 months of death)

Date of operation 11/43 — 8/23/44

Major findings of operation: strangulated hernia

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature George J. Kayer, M.D.

Address Monument & Broadway Date signed 8/23/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

For Dr Rob. Hudson, Asst Supt & Medical Dir.

YANSURA

223 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G20223

CERTIFICATE OF DEATH 1930

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 3433 Old Frederick Rd. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Katie wife Yansura 20-8

(a) Residence: No. 3433 Old Frederick Rd St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb 25 1878

7. AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
66	5	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Hungary

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Daughter

(Address) 3433 Old Frederick Rd.

18. BURIAL, CREMATION, OR REMOVAL

Place Greek Orthodox Cem. Date Aug 5 1944

19. UNDERTAKER J. Francis Leese

(Address) Westminster

20. FILED 8/25/44 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) August 22 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept 1937 to Aug 22 1944

I last saw h[illegible] alive on Aug 21 1944 Death is said to have occurred on the date stated above, at 11:10 a m

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	3 days

Other contributory causes of importance:

Arterio-Sclerosis	6 Months
Diabetes	

Was an operation performed? No Date of

For what disease or injury?

What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Eliot W Johnson M. D.

(Address) 3432 Frederick Road

G20224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83

Registered No. G20224

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 S. Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 S. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Kohlhafer

3 (b) If veteran, name war	3 (c) Social Security Account No.	4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
—	None	Female	White	Widowed

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 5 - 1864

8. AGE: Years	Months	Days	If less than one day
80	6	20	....hr. ....min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Kahl
13. Birthplace Germany

MOTHER
14. Maiden Name Annie —
15. Birthplace Germany

16 (a) Informant Robert E. Kohlhafer
(b) Address 1611 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location East. End of North Ave

18 (a) Funeral director Earl L. Haess
(b) Address 715 Light St.

19 (a) AUG 25 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25- 1944, at 7:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Cerebral Hemorrhage, Apoplexy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 8-26-44

MARG RESERVED FOR BI ING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure the information you give is correct are is especially important.

G20225

TN. 89394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93-D

G20225 Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address B 4940 Eastern Ave

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1157 E. Lombard St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Lucas

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Sept.

6 (b) Name of husband or wife: ROSE MAY LUCAS

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/83 ?

8. AGE: Years 60 | Months 7 | Days 22 | If less than one day: hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name James Lucas

13. Birthplace Va.

MOTHER — 14. Maiden Name Mary ?

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals

(b) Address 4940 Eastern Ave (Records

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 26/44 (month) (day) (year)

(c) Cemetery or crematory OAK LAWN

Location EASTERN AVE EXT.

(d) Funeral director Lilly and Geiler INC

(e) Address AUG 25 1944 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/44 19 , at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-7 1944 to 8-23-1944, and that I last saw him alive on 8-23 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions Arteriosclerosis
Heart disease
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature E. L. Seigman M.D.

Address BCH Date signed 8/25/44

G20226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1146-C

Registered No. G20226

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3647 Elmley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine F. Cuddy — G 0 7589

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Married

6 (b) Name of husband or wife Joseph F. Cuddy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13 - 1924

8. AGE: Years	Months	Days	If less than one day
19	11	11	hr. min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Hughey
13. Birthplace Penna.

MOTHER
14. Maiden Name Louise Eddy
15. Birthplace Penna.

16 (a) Informant Joseph F. Cuddy
(b) Address 3647 Elmley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Flynn & Fleming
(b) Address 1416 Light St.

19 (a) (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 24 1944, at 3:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1944 to Aug. 24 1944 and that I last saw h.e.r alive on Aug. 24 1944

Immediate cause of death Shock due to post-partum hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul G. Galeotis
Address 1213 Light St. Date signed 8/24/44 M.D.

G20227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 a

Registered No. G20227

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1503 W. Lanvale St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Riess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27-1892

8. AGE: Years	Months	Days	If less than one day
51 52	7	27	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Restaurant owner

11. Industry or business

FATHER
12. Name Jacob Riess
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Marie Schmidt
15. Birthplace Germany

16 (a) Informant Mrs Geo Gude
(b) Address 3613 Old York Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 26-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem
Location Frederick Rd Balto Md

18 (a) Funeral director Matton Schellberg
(b) Address 3914 S. Hanover St

19 (a) AUG 25 1944 (b) Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23/1944, at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20/1944, to 8/23/1944, and that I last saw h[illegible] alive on 8/23/1944.

Immediate cause of death	Duration
Cerebral hemorrhage [sub-arachnoid]	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy Sub-arachnoid hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dr. Carl Myers

Address Md. Gen. Hosp. Date signed 8/24/44

G20228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93-D

G20228 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2444 W. Baltimore St
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2444 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Sarah Elizabeth Keating

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Nellie L. Keating

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) January 26 1871

8. AGE: Years	Months	Days	If less than one day
73	7	29	— hr. — min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John F. Redmond
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Augusta Hunter
15. Birthplace Baltimore, Md

16 (a) Informant Nellie L. Keating
(b) Address 2444 W. Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/44 (month) (day) (year)

(c) Cemetery or Crematory Loudon Park
Location Baltimore, Md

18 (a) Funeral director F. D. Gaffney & Son
(b) Address Eastern Ave. & Lamdin St

19 (a) AUG 29 1944 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24 1944 at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1944 to 8/24 1944 and that I last saw h of alive on 8/15 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 hr

Due to

Due to

Other Conditions Arteriosclerotic CV disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles F. Lubrinski M.D.

Address 5217 Portsmouth Rd Date signed 8/24/44

G20229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119-W Registered No. G20229

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Eutaw
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1129 Ward St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby mary Pindell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 2nd 1944

8. AGE: Years	Months	Days	If less than one day
—	—	24	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name mary Pindell

13. Birthplace

MOTHER 14. Maiden Name allen Pindell

15. Birthplace

16 (a) Informant Mary Pindell
(b) Address 1129 Ward St

17 (a) Burial (b) Date thereof Aug 26/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral directors J. J. Wolfgang & Son
(b) Address 300 Eutaw Place

19 (a) AUG 25 1944 Huntington Williams M.D.
(Date received by local registrar) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24 1944, at 1:30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23 1944, to 8-24 1944, and that I last saw h[illegible] alive on 8-24 1944.

Immediate cause of death	Duration
Dehydration & malnutrition	
Due to Infectious diarrhea	2 wks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Johns Hopkins Hosp. Date signed 8-24

G20230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92-B

G20230 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3220 Barclay Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3220 Barclay Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Kutch

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8946

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Edna J Kutch

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Frederick Kutch
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret J. Jennup
15. Birthplace Maryland

16 (a) Informant Edna J. Kutch
(b) Address 3220 Barclay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore Md

18 (a) Funeral director Robert E. Jennings
(b) Address 1501 madison ave
AUG 25 1944 (c) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1944, at 9:45 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Valvular heart disease
mitral insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
By Medical Examiner.
Date signed August 23, 1944.

G20231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20231

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 221 N. Arlington Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 221 N. Arlington Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse-Mae [illegible] Wise

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
0	0	0	5 hr. 40 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Jesse McKnight
13. Birthplace Myrtle Beach S. C.

MOTHER
14. Maiden Name Margaret Wise
15. Birthplace Amelia Va.

16 (a) Informant Margaret Wise
(b) Address 221 N Arlington Ave, Balto.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 25 1944

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1944, at 8.40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4:30 Aug 23 1944, to 7:30 A.M. Aug 23 1944, and that I last saw [illegible] alive on Aug. 23 1944.

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 1

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. D. Mannon M. D.
Address Univ. Hosp. Date signed

VS 150

2110

G20232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 154

Registered No. G20232

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Fayette and Collington Sts.

(c) Hospital or institution: Franklin Square Hosp.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) Franklin Sq. Hosp.

(d) Street No. 3014 Walbrook Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Reginald Duane Spears Twin #1

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Newborn			8 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Charlie Lee Spears

13. Birthplace Congo N. C.

MOTHER — 14. Maiden Name Lera Myrtle Brooks

15. Birthplace Worth W. Va

16 (a) Informant Mother

(b) Address 3014 Walbrook Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL AUG 25 1944

18 (a) Funeral director Commissioner of Health

(b) Address

AUG 26 1944 Huntington Williams, M.D.

(Date received by registrar) Registrar

VS 166

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/44 19 , at 4:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7:52 AM to 4:57 PM and that I last saw h[illegible] alive on 8/24/44

Immediate cause of death — Duration

Due to

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of [illegible]

23. Signature Thomas Clyde Webster

Address Franklin Sq. Hosp Date signed 8/25/44

2109

G20233

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

154

G20233
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette Ave Collamore
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr 15 m
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Northwest Baltimore Martin G. Hopp
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Wallbrook ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Charles Spears Twin #2

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/24/44

8. AGE: Years Newborn | Months | Days | If less than one day 1 4 hr. min.

9. Birthplace Franklin Square Hosp
(Town, county and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name Charles Lee Spears
13. Birthplace Congo N.C.

MOTHER — 14. Maiden Name Iva Myrtle Foster
15. Birthplace Wirt. W. Va

16 (a) Informant Mother
(b) Address 3014 Wallbrook Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL AUG 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 AUG 25 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/24/44 19 , at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7:15 A.M. to 11:00 P.M. and that I last saw h.i.m. alive on 8/24/44 19

Immediate cause of death	Duration
Due to	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Clyde Wilson
Address Franklin Sq. Hosp Date signed 8/25/44

2103

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137-

G20234 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address RUTLAND & MONUMENT ST.
(c) Hospital or institution: SINAI HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1182 WASHINGTON BLVD. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Hampton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWED

6 (b) Name of husband or wife JOSA If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 2, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	23	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation COACH PAINTER
11. Industry or business RETIRED

FATHER
12. Name JOHN HAMPTON
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace

16 (a) Informant MRS. RICHARD HAMPTON
(b) Address 1182 WASHINGTON BLVD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 8-28-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON
Location BALTO., MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTIMORE, MD.

19 (a) AUG 26 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1944 at 1:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug 25 1944, and that I last saw him alive on Aug 25 1944.

Immediate cause of death	Duration
Uremia	
Due to Chronic pyelonephritis	
Due to Hydronephrosis & hypertrophy of prostate	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Hellon M. D.
Address Sinai Hosp Date signed 8/25/44

G20235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20235 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2609 Shirley Avenue.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County ---

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 2609 Shirley Avenue. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter L. Weidemann

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband ~~WIFE~~ Grace H. Weidemann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7th 1882

8. AGE: Years	Months	Days	If less than one day
62	2 1	17	...hr. ...min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

MOTHER / FATHER

12. Name Not Known

13. Birthplace Denmark

14. Maiden Name Jennie Bond

15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Grace H. Weidemann

(b) Address 2609 Shirley Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 26th 1944 (month) (day) (year)

(c) Cemetery or ~~CREMATORY~~ Mt. Olivet

Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.,

(b) Address North & Penna Aves. Baltimore, Md.

19 (a) AUG 26 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1944, to Aug 24 1944 and that I last saw h[im] alive on Aug 24 1944.

Immediate cause of death Acute Pneumonia

Due to Chronic Bronchitis

Due to Ch Diabetes

Duration

Other Conditions Coronary insufficiency

(Include pregnancy within 3 months of death)

Date of operation ---

Major findings of operation: ---

of autopsy: ---

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide ---

(b) Date of occurrence ... at ... M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature A. H. Hornstein M. D.

Address 733 Augusta St. Date signed 8/25/44

G20236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B Registered No. G20236

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3913 Boarman Avenue.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3913 Boarman Avenue. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie B. Pitcher

3 (b) If veteran, name war: ---
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband Edwin H. Pitcher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 19th 1880

8. AGE: Years	Months	Days	If less than one day
64	0	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name William Butler
13. Birthplace Maryland

MOTHER
14. Maiden Name Mollie Brian
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Edwin Hayer Pitcher
(b) Address 3913 Boarman Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 28th 1944 (Month, day, year)
(c) Cemetery or ~~crematory~~ Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves. Baltimore, Md.

AUG 26 1944 (Date received) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25th 1944, at 5 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 1944, to Aug 25 1944, and that I last saw her alive on Aug 24 1944

Immediate cause of death: Carcinoma of Liver (primary site unknown)
Due to:
Due to:
Other Conditions: Acute pulmonary oedema
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration
3 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. Lee Hitchens, M.D.
Address 4116 North Ave Date signed 8/14/44

G20237

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2141 Chelsea Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2141 Chelsea Terrace (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Stella May Kirwan

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband George L. Kirwan
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 29th 1865

8. AGE: Years	Months	Days	If less than one day
79	6	25	..... hr. ..... min.

9. Birthplace Deals Island, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John W. Gibson
13. Birthplace Maryland

MOTHER
14. Maiden Name Melvenia Benton
15. Birthplace Maryland

16 (a) Informant Mrs. Edna Johnson
(b) Address 2141 Chelsea Terrace.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 28-1944 (month) (day) (year)
(c) Cemetery Lorraine
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.,
(b) Address North & Penna Aves. Baltimore, Md.

19 (a) AUG 26 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24th 1944, at 5.30P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1942, to Aug 24 1944, and that I last saw h-r alive on Aug 24 1944

Immediate cause of death	Duration
Myocarditis	6 mo.
Due to advanced arteriosclerosis	?
Due to	
Other Conditions Arterio Sclerosis	?

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury .....

23. Signature Stella S. Wolfe M. D.
Address 2220 Herring Blvd Date signed Aug 25/44

C20238 HEALTH DEPARTMENT—CITY OF BALTIMORE C20238

CERTIFICATE OF DEATH

97

1. PLACE OF DEATH 2117 Dennison St.

CITY OF BALTIMORE: (No. The Crawford Retreat St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Carrie Hewitt

If U.S. Veteran specify WAR

(a) Residence: No. 2117 Dennison St. St., 15-7 Ward

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F.	W.	SINGLE

3a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) May 12, 1857

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	3	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. —

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) BALTIMORE, MD.

FATHER

13. NAME HORATIO HEWITT

14. BIRTHPLACE (city or town) (State or country) BALTO. MD.

MOTHER

15. MAIDEN NAME MARIA GADE

16. BIRTHPLACE (city or town) (State or country) BALTO. MD.

17. INFORMANT MRS. FLORENCE WATKINS

(Address) COCKEYSVILLE, MD.

18. BURIAL, CREMATION, OR REMOVAL

Place GREENMOUNT Date 8-28 1944

19. UNDERTAKER WM. J. TICKER & SONS

(Address) BALTO., MD.

20. FILED AUG 26 1944 19 Huntington Willis Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 24 1944

22. I HEREBY CERTIFY, That I attended deceased from Aug. 1st 1944 to Aug. 24th 1944

I last saw her alive on Aug. 24 1944. Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Uraemia	8/20/44
Other contributory causes of importance: Arteriosclerosis	1900

Was an operation performed? no Date of —

For what disease or injury? —

What test confirmed diagnosis? — Was there an autopsy? —

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? no Date of injury — 19—

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no If so, specify

(Signed) M. J. McDermott M. D.

(Address) 4136 Poplar Grove St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. Entries must be made in information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

VS 3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20239 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2836 Alameda Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2836 Alameda (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hill

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-3946

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1879

8. AGE: Years 65 Months 6 Days 21 If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER 12. Name James A. Hill

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Mary M. Dratz

15. Birthplace Baltimore Md

16 (a) Informant Catherine Hill

(b) Address 2836 Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/26/44 (month) (day) (year)

(c) Cemetery or crematory Dulaney Ridge

Location Hendon Park Hyattsville

18 (a) Funeral director W. W. E. Pepper's Sons

(b) Address homeland r Ave Sta.

19 (a) [illegible]

AUG 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 19 44 Aug 23 19 44 and that I last saw [illegible] alive on Aug 23 1944

Immediate cause of death

Due to McKinney

Due to Bronchitis

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Burial Cremation

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edgar A. Mitchell M. D.

Address 1500 N Milton Ave Date signed 8-24-44

G20240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83-a

G20240 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 E. 33rd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 E. 33rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret B. Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband: William T. Watson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10th 1873

8. AGE: Years 71 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name George A. Smith
13. Birthplace Md.

MOTHER
14. Maiden Name Babbetta Schmidt
15. Birthplace Germany

16 (a) Informant Carroll S. Mitchell
(b) Address 1702 E. 33rd St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 8/26/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St

19 (a) AUG 26 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 23rd 1944 at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1944 to Aug 23 1944 and that I last saw her alive on Aug 23 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day

Due to:

Due to: Chr. Hypertension arterio-Sclerosis — Duration: ?

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L N Meyer Jr

Address 1520 E. 33rd St Date signed 8/24/44 D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

B 6971 G20241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 45-4 G20241
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 Broward Av.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Betty Jones Lucas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Rev. Jos. Lucas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-91

8. AGE: Years 63 | Months 2 | Days 26 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name George Epps
13. Birthplace (Va)

MOTHER
14. Maiden Name unknown.
15. Birthplace Va.

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location [illegible] Md.

18 (a) Funeral director [illegible] Alexander
(b) Address 927 N. Mount St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1944, at 3:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23-1944 to 8-27 1944 and that I last saw her alive on 8-27-1944.

Immediate cause of death

Due to Lymphoblastic Lymphosarcoma arising in

Due to Nasopharynx

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cohen
Address J. Hopkins H. Date signed 8-27-44 M. D.

G20242

JL - 85838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52-B

G20242 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mo. 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 25-2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Kinsella

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Late Mary A. Kinsella
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1870

8. AGE: Years	Months	Days	If less than one day
73	9	21	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name James Kinsella
13. Birthplace Ireland

MOTHER
14. Maiden Name Hanna Moffett
15. Birthplace Penna.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28/1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director Chas J. Cowan & Son
(b) Address 901 Hollins St. Baltimore, Md.

19 AUG 26 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24-44 19 , at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1-6 19 44, to 8-24 19 44, and that I last saw him alive on 8-24 19 44.

Immediate cause of death: Uremia — Duration 6 wks

Due to: Carcinoma Urinary Bladder — 2½ yrs.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Hydronephrosis & Pyelonephritis

of autopsy: Pulmonary Thrombosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hauck E. Belton M. D.
Address City Hosp. Date signed 8/25/44

G20243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20243
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ernest Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 5 1933

8. AGE: Years	Months	Days	If less than one day
10	4	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Sidney Johnson
13. Birthplace Md-

MOTHER
14. Maiden Name Mary Hunt
15. Birthplace VA

16 (a) Informant hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Signature of local registrar) (b) Huntington Wilson Registrar

AUG 26 1944
Vs mo

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1944, at 8.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1944, to Aug 24 1944, and that I last saw h.. alive on Aug 24 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to	
Bulbar poliomyelitis	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H.D. Smith M. D.
Address Sydenham Hosp Date signed 8.29

G20244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G20244 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 601 N. Hennison St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 601 N. Hennison St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora B. Bayer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Andrew George Bayer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1873

8. AGE: Years	Months	Days	If less than one day
71	5	28	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Home wife

11. Industry or business

FATHER
12. Name George Bayer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Briel
15. Birthplace Germany

16 (a) Informant George Bayer
(b) Address 601 N. Hennison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Balto, Md

18 (a) Funeral director Harry H. Wentzell
(b) Address 4401 Edmondson Ave

19 (a) (Date rec'd by Registrar) AUG 28 1944 Registrar

VS 1 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25/44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 19 44 to Aug 25/44.
and that I last saw h alive on Aug 1 19 44

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Urban Smith M. D.
Address 817 Park Ave Date signed Aug 28 1944

C. Urban Smith

G20245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20245
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Aves
(c) Hospital or institution: Md. Gen. Hosp. 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 60 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1923 Maund St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E. Larkin

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife late John T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5 1875

8. AGE: Years 68 | Months 10 | Days 8 | If less than one day ___ hr. ___ min.

9. Birthplace Penn Twp. Penn Twp. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Bryan
13. Birthplace Penn Twp. Penn Twp. Co. MD

MOTHER
14. Maiden Name Mary E. Moore
15. Birthplace Md.

16 (a) Informant Joseph McGuirk
(b) Address 600 N. Augusta Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 3900 Old Frederick Rd.

18 (a) Funeral director Harry A. Wittke
(b) Address 4101 Edmondson Ave

19 (a) (Date received by Registrar) AUG 26 1944 (b) Registrar Huntington Hillcrest, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1944 at 7:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/26 1944 to 8/25 1944, and that I last saw h[illegible] alive on 8/25 1944

Immediate cause of death	Duration
Diabetes Mellitus	
Due to	
Due to	
Other Conditions Gangrene of amputation (Include pregnancy within 3 months of death)	

Date of operation 7/24/44
Major findings of operation: Gangrene left leg.
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Carl Myers M. D.
Address Md. Gen. Hosp. Date signed 8/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44-

G20246 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2330 Eutaw Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2330 Eutaw Place (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Frederick R. Simmons
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widower
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1883
8. AGE: Years 61 Months — Days — If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Navy Dept
FATHER 12. Name John F. Simmons
13. Birthplace Baltimore Md
MOTHER 14. Maiden Name — Unknown
15. Birthplace —
16 (a) Informant Thomas Simmons
(b) Address 2320 Eutaw Place
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn County
Location —
18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E. 32nd St
19 (a) (Date rec'd by registrar) (Hunterstown Adams County Pa)

AUG 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1944, at 7a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 19 to 19, and that I last saw h. alive on Aug 25 1944 M.

Immediate cause of death Coronary Thrombosis (was found dead in bed) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Kaden M. D.
Address 2306 Eutaw Pl Date signed 8-26-44

Approved by Howard J. Maddux, M.D. Baltimore, Md

N. P. S. 1935-6

20247 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G20247

CERTIFICATE OF DEATH

55-B

1. PLACE OF DEATH

Registered No.....

CITY OF BALTIMORE: (No. 3317 Brighton St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... da. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... da.

2. FULL NAME William Ennis Taylor

(a) Residence: No. 3317 Brighton St Ward. 16-7

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6. DATE OF BIRTH (month, day, year): Sept 24-1907

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
37	11	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Painter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Self

10. Date deceased last worked at this occupation (month and year): 11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Salisbury Md

FATHER

13. NAME: J. Ryland Taylor

14. BIRTHPLACE (city or town) (State or country): Salisbury Md

MOTHER

15. MAIDEN NAME: Fanny E. Ennis

16. BIRTHPLACE (city or town) (State or country): Salisbury Md.

17. INFORMANT: Idella M. Taylor

(Address) 3317 Brighton Street

18. BURIAL, CREMATION, OR REMOVAL

Place: Salisbury Md. Date: Aug 29 1944

19. UNDERTAKER: Holloway & Co

(Address) Salisbury Md. H. Taylor Williams

20. FILED AUG 26 1944 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Aug 26 - 1944

22. I HEREBY CERTIFY, That I attended deceased from July 12 1944 to Aug 26- 1944

I last saw h.. alive on Aug 25 1944 Death is said to have occurred on the date stated above, at 2 A. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Sarcoma — Left Knee	2 yrs

Other contributory causes of importance:

None known

Excision inguinal glands — Date of 1943

Name of operation ..... Date of .....

What test confirmed diagnosis? Path. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Chas. J. Keller M. D.

(Address) 222 W. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20248
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2009 Whittier Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie Silver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Late Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: Housewife

FATHER
12. Name: Mendel Weitzman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Rose
15. Birthplace: Russia

16 (a) Informant: Joseph Silver
(b) Address: 2009 Whittier Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug, 27, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rosedale Cem
Location: Hamilton Ave

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1126 W North Ave

AUG 27 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1944, at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1944 to Aug 24 1944, and that I last saw her alive on 8/24/44.

Immediate cause of death: Acute Cardiac failure

Due to: ch. myocarditis

Due to: ch. Bronchial asthma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Horsteins

Address 733 augusta st Date signed 8/26/44
M. D.

G20249 BALTIMORE CITY HEALTH DEPARTMENT G20249

CERTIFICATE OF DEATH 106 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: W. B. G. H.
(a) Baltimore City, Maryland
(b) Street address 3904 Dolfield Blvd.
(c) Hospital or institution: W. B. G. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

15 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Dolfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ABRAHAM KRESHTOOL Kreshtool

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-09-8257

4. Sex m. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Ida
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/889

8. AGE: Years 54 | Months 8 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business Painter

FATHER
12. Name Kopel Kreshtool
13. Birthplace Poland

MOTHER
14. Maiden Name Rifka ?
15. Birthplace Poland

16 (a) Informant Ida Kreshtool
(b) Address 3904 Dolfiel Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug, 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location 3600 E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

AUG 27 1944

19 (a) (Date rec'd by registrar) (b) Registrar

Thurlington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/25 1944, at 8:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/20 1944 to 19..., and that I last saw h[e] alive on 8/25 1944.

Immediate cause of death Bronchestasis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M. D.
Address W B G H Date signed 8/26/44

G20250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20250

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2638 Gulford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2638 Gulford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Egra C Miller

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth E Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22.1886

8. AGE: Years 58 | Months 2 | Days 4 | If less than one day: hr. min.

9. Birthplace Capon Bridge W Va (Town, county, and state)
10. Usual Occupation Druggist
11. Industry or business Store
12. Name of FATHER: John H Miller
13. Birthplace W Va
14. Maiden Name of MOTHER: Elizabeth E Miller
15. Birthplace W Va

16 (a) Informant: Lt Marriger H Miller
(b) Address 2638 Gulford Ave

17. (a) Burial, (b) Date thereof 8/28/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Forkwood
Location Foxhall & 36

18 (a) Funeral director Wilson Corbin
(b) Address 1217 E Fort Ave

19 (a) AUG 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1944, at 3:6 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1940 to Aug 26 1944 and that I last saw him alive on August 25 1944

Immediate cause of death	Duration
Coronary thrombosis	1 year
Due to arteriosclerosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Egbert H. Mortimer MD
Address 2706 St Paul St Date signed 8/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20251 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2905 Chesley Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2905 Chesley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick J. Schlissler

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-16-8797

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Raina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 16-1869

8. AGE: Years 74 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Retired Butcher

11. Industry or business

FATHER
12. Name Herman Schlissler
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Glatz
15. Birthplace Balto

16 (a) Informant Raina Schlissler
(b) Address 2905 Chesley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/28-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Parkville - Balto Co.

18 (a) Funeral director Wm Cook Inc
(b) Address 1317 St Paul St

19 (a) AUG 27 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25. 1944 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 22 1944, to Aug 25 1944, and that I last saw h.. alive on Aug. 25 1944.

	Duration
Immediate cause of death: Acute Pulmonary Edema	12 hrs.
Due to: Arteriosclerotic cardiovascular	2 yrs.
Due to: Disease Generalized edema	2 wks.
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address 6217 Harford Rd Date signed 8/29/44 (M. D.)

G20252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G20252
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2124 Ridgehill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2124 Ridgehill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dave Rosen

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Dora
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880
8. AGE: Years 64 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Shoe Maker (self)
11. Industry or business

FATHER
12. Name unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Sam Rosen
(b) Address 2124 Ridgehill Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-44 (month) (day) (year)
(c) Cemetery or crematory Theater Balto. Lodge
Location Hebrew Memorial Park
18 (a) Funeral director Isaac Levin Inc
(b) Address 1439 E. Baltimore St. Baltimore, Md.
19 8-27-1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1944 at 7P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 28 1943, to Aug. 25 1944 and that I last saw h[illegible] alive on Aug 24 1944.

Immediate cause of death: Chronic Myocarditis — Duration 2 yrs
Due to: Arteriosclerotic Cardiovascular Renal Disease
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Samuel Wolfe
Address 1331 S. Northlane Date signed 8-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20253

1. PLACE OF DEATH: W. B. G. H.
(a) Baltimore City, Maryland
(b) Street address Payne Ave & Oakland St
(c) Hospital or institution W. B. G. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) 48 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Balto (b) County
(c) City or town Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2016 N. Smallwood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose S. Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Ralph A. Cohen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: 49 Years | Months | Days | If less than one day hr. min.

9. Birthplace Russia Poltz. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Louis Lindlar
13. Birthplace Poltz.

MOTHER
14. Maiden Name Unknown
15. Birthplace Poltz.

16 (a) Informant Irvin Cohen
(b) Address 2016 N. Smallwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-27-44 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cem.
Location Northern Ave.

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Balto. St

AUG 27 1944 (b) Huntington Williams
(Entered by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1944 at 9 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/8 1944 to 8/25 1944 and that I last saw h-- alive on 8/25 1944

Immediate cause of death: Acute Myeloid Leukemia — Duration: 5 mos+

Due to

Due to

Other Conditions: Ischio-rectal abscess — Duration: 5 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Irving Taylor

Address W B G H Date signed 8/26/44 M. D.

G20254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20254
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bayner Ave and Dukeland St
(c) Hospital or institution:
West Baltimore Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 da
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4212 Berger Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank C. Koch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eva

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1874

8. AGE: Years 70 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Koch
13. Birthplace Germany

MOTHER
14. Maiden Name Estelle E. ?
15. Birthplace Germany

16 (a) Informant Mac Eul Koch
(b) Address 4212 Berger Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-28-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5305 Harford Rd

19 (a) Date received by registrar AUG 27 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1944, at 9:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from August 22 1944, to August 24 1944, and that I last saw him alive on August 24 1944.

	Duration
Immediate cause of death: Uremia	
Acidosis	
Due to: Nephro-sclerosis	
Chronic Glomeruli Nephritis	
Due to: HCVD	
Chronic cystitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Chronic Nephritis — Cystitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M. D.
Address WBGH Date signed 8/24/44

G20255 BALTIMORE CITY HEALTH DEPARTMENT G20255

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 440 Rosebank Ave. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Benjamin Franklin Calvert.

3 (b) If veteran, name war	3 (c) Social Security Account No.
No.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married.

6 (b) Name of husband or wife Beulah Calvert. Nee Taylor
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 7, 1882

8. AGE: Years	Months	Days	If less than one day
62	6	18	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Balto. Museum of Arts

FATHER
12. Name Benjamin F. Calvert
13. Birthplace Anne Arundel Co. Md.

MOTHER
14. Maiden Name Minerva Younk
15. Birthplace Kentucky

16 (a) Informant Mrs. Frank Calvert.
(b) Address 440 Rosebank Ave. Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md
18 (a) Funeral director Thomas W Singleton
(b) Address Glen Burnie, Md

8 27 1944 (b) Hampton Wilkins, M.D.
(Date rec'd by registrar)

VS 4

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1944 at 3:45 PM

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said autopsy found that said deceased came to death on the day stated above.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 8-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING. The PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 55E

Registered No. G20256

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7da
(e) Length of stay in Baltimore (yrs., mos., or days) 7da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Emma J. Myers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1863

8. AGE: Years 81 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Josiah Englar

13. Birthplace Maryland

MOTHER 14. Maiden Name Caroline Feaja

15. Birthplace Maryland

16 (a) Informant E. McClure Bowyer

(b) Address 3908 N. Charles St. Balto. Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug-29-44 (month) (day) (year)

(c) Cemetery or crematory Westgate Cemetery

Location New Windsor Md

18 (a) Funeral director D. D. Hartle & Son

(b) Address New Windsor Huntington Williams Md

19 (a) AUG 28 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944 at 905 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1944, to Aug 27 1944, and that I last saw h[illegible] alive on Aug 27 1944.

Immediate cause of death Cardio-respiratory failure — Duration: Years.

Due to Hypertensive Cardio-Vascular Disease — Duration: [illegible]

Due to — Duration: [illegible]

Other Conditions Carcinomatosis — Duration: 6 mos.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glenn O. Bowyer M. D.

Address Union Memorial Hosp. Date signed 8-27-44

G20257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G20257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert W. George.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	M.

6 (b) Name of husband or wife Mary G. Lewis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1863.

8. AGE: Years	Months	Days	If less than one day
81	1	15	hr. min.

9. Birthplace Memphis Scotland
(Town, county and state)

10. Usual Occupation Coal Miner

11. Industry or business Ret.

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Family
(b) Address 815 W. Franklin St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)

(c) Cemetery or crematory Oak Hill Cem.
Location Lynchburg, Va.

18 (a) Funeral director Jas L. McCauley
(b) Address 130 E. Fort Ave.

19 AUG 28 1944 (Date rec'd by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26, 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to Aug 26 1944, and that I last saw him alive on Aug 25 1944

Immediate cause of death	Duration
Cardiac Failure	1 wk.
Due to Senility.	
Due to Arteriosclerosis advanced.	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo E. Wells M. D.
Address 410 Edmondson Ave. Date signed 8/27/44

G20258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G20258 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Linden Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie C. Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife: William Sanford

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1864

8. AGE: Years 79 | Months 9 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Providence, Balto., Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business Housewife

FATHER
12. Name William Corbin
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine Stemmer
15. Birthplace Pa.

16 (a) Informant Mr. William S. Smith
(b) Address 1735 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) AUG 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1944 at 5:15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 6 1940 to Aug 26 1944 and that I last saw her alive on Aug 26 1944

Immediate cause of death	Duration
Coronary occlusion	2 days
Due to Myocardial degeneration	4 yrs
Due to Hypertension	12 yrs
Due to Chronic Nephritis	12 yrs.
Other Conditions Arteriosclerosis	—
Advanced age	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations —
of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M.
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Parke E. Baggott M. D.
Address 3812 Greenmount Ave. Date signed Aug 26 44

G20259

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G20259

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5216 Gwynn Oak Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 5216 Gwynn Oak Ave.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Hibernia Pate

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Rev. Chas. L. Pate

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 23, 1866

8. AGE: Years 78 | Months 3 | Days 2 | If less than one day: hr. min.

9. Birthplace: Frostburg, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Gabriel T. MacKenzie
13. Birthplace: Md.

MOTHER
14. Maiden Name: ? Greenwade
15. Birthplace: ?

16 (a) Informant: Mrs. Harry B. French
(b) Address: 5216 Gwynn Oak Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Aug. 28, 1944 (month) (day) (year)

(c) Cemetery or crematory: Druid Ridge
Location: Pikesville, Md.

18 (a) Funeral director: Wm. J. Tickner & Sons, Inc.

(b) Address: North & Pa. Aves.

19 AUG 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25, 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942 to 8/25/44 1944; and that I last saw h[illegible] alive on 8/23/44

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 Wk

Due to: Arterio Sclerosis — Duration: ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature: H. O. Harper, M. D.

Address: 5701 Evergreen Ave. Date signed: 8/26/44

G20260

G20260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
Street address
Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2706 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY BABYLON or Marian Babylon

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Married

6 (b) Name of husband or wife Klair D.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1 1905

8. AGE: Years	Months	Days	If less than one day
38	10	26	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Fitzhugh
13. Birthplace Miss.

MOTHER
14. Maiden Name Ethel Blaine
15. Birthplace Canada

16 (a) Informant Mr. Klair D. Babylon
(b) Address 2706 Maryland Ave.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Branch
Location Carroll Co. Md

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 AUG 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944, at 1 50 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, lobar right
Pleurisy Chronic suppurative

Due to
Barbital Secnal poisoning

Other Conditions Schizophrenia
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-21-44 at 7 P. M.
(b) Where did injury occur? home address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury Secnal-barbital

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 8-27-44

G20261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G20261 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2027 E. Balto. St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2027 E. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA HURWITZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife David Hurwitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
64			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Dawn David Hurwitz
13. Birthplace Russia

MOTHER
14. Maiden Name Miriam
15. Birthplace Russia

16 (a) Informant David Hurwitz
(b) Address 2027 E. Balto. St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-44 (month) (day) (year)
(c) Cemetery or crematory Adas Israel
Location North Point & German Hill Rd

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1439 E. Balto St

19 AUG 28 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 27 1944, at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 25 1944, to AUG 27 1944, and that I last saw her alive on AUG 25 1944.

Immediate cause of death Cardiac failure — Duration

Due to Coronary occlusion

Due to Generalized arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isadore Shronfeld M.D.
Address 601 N. Monroe St. Date signed Aug 27 1944

G20262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 146c

Registered No. G20262

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address U. M. Hospital
(c) Hospital or institution: 13

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Chestnut ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME MAY Evelyn Sharp

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-03-2895

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W	married

6 (b) Name of husband or wife John Francis Sharp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 6, 1920

8. AGE: Years	Months	Days	If less than one day
24	6	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, or state)
10. Usual Occupation Painting Chemical Co
11. Industry or business House.

FATHER
12. Name Cl. Hord L. Woolside.
13. Birthplace New Jersey.

MOTHER
14. Maiden Name Evelyn Myrtle Allport.
15. Birthplace Maryland.

16 (a) Informant Hospital Record,
(b) Address

17 (a) Burial (b) Date thereof Aug 28-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3621 Fells Road

19 AUG 28 1944 (b) Huntington Baltimore, Md.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8-25 1944, and that I last saw her alive on 8-25 1944.

Immediate cause of death	Duration
Peripheral vascular Collapse	
Due to Post Partum Hemorrhage.	
Due to Uterine Inertia.	
Other Conditions Pregnancy. Induction of Abortion of Immature Twins	

(Include pregnancy within 3 months of death)

Date of operation 8-25-44.

Major findings of operation: Relaxed Boggy, non contracted Uterus

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Morris, M.D.
M. D.
Address UMH Date signed 8-25-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1167

Registered No. G20263

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) Died
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 S. Eaton St. (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HERMAN J. BROWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine Brown

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) April 26, 1906

8. AGE: Years	Months	Days	If less than one day
38	4	1	hr. min.

9. Birthplace: Chester Maryland (Town, county, and state)

10. Usual Occupation: Truck Driver

11. Industry or business

FATHER
12. Name: Richard J. Brown
13. Birthplace: Shaftsbury Maryland

MOTHER
14. Maiden Name: Harriet Dorman
15. Birthplace: Shaftsbury Maryland

16 (a) Informant: Maggie Brown
(b) Address: 1 Robert Hamby St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 44 (month) (day) (year)

(c) Cemetery or crematory: Chester Md.
Location: Kent Island

18 (a) Funeral director: Edwin A. Hammett
(b) Address: Centreville Md.

AUG 28 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 26 1944 at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH: Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-26-44 at 12:45 P.M.
(b) Where did injury occur? Fremont Ave near Brown St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Knife ? - altercation

23. Signature H. J. Williams M.D. Medical Examiner.
Date signed 8-27-44

G20264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1939

G20264
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dau
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 S Streeper St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA V BENNETT

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frank Bennett

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Aug 13 - 1891

8. AGE: Years 53 | Months — | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Geo McCracken
13. Birthplace Balto

MOTHER
14. Maiden Name Dora Reinish
15. Birthplace Baltimore

16 (a) Informant Frank Bennett
(b) Address 510 S Streeper St

17 (a) Burial (b) Date thereof Aug 28
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-6 Orleans St

19 (a) (Registered by registrar) (b) Huntington Williams M.D.

AUG 28 1939
VS 1st 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1939 at 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 8-26-39

G20265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G20265

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 N. Luzerne ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 N. Luzerne ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Fielmann

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Herman W. Spielman

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) Jan 24 1914

8. AGE: Years 30 | Months 7 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business At home

FATHER
12. Name William S. Lee
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mamie Donohue
15. Birthplace Baltimore

16 (a) Informant Mrs Herman W. Spielmann
(b) Address 429 N. Luzerne ave

17 (a) Burial (b) Date thereof Aug 28
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

19 (a) (Date received by Local Registrar) AUG 28 1944 Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24- 1944, at 7-15 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subdural Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Williams M.D.
Medical Examiner.
Date signed 8-25-44

G20266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20266 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital 96

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Canton Circle
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Eastern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORMAN PERKINSON

3 (b) If veteran, name war	3 (c) Social Security Account No. 213-07-9322

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Leanora Perkinson
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feby. 1885

8. AGE: Years	Months	Days	If less than one day
59	6		hr. min.

9. Birthplace: Wise N C
(Town, county, and state)

10. Usual Occupation Machinist
11. Industry or business Bethlehem Steel

FATHER
12. Name Nathaniel J Perkinson
13. Birthplace N C

MOTHER
14. Maiden Name Patty Tenell
15. Birthplace N C

16 (a) Informant Mrs R L Frazier
(b) Address 17 N East Ave

17 (a) Remove (b) Date thereof Aug 28 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wise Mem. Pk.
Location Wise N C

18 (a) Funeral director Ellers Funeral Home
(b) Address 2004 E. Oliver

19 (a) AUG 28 1944 Huntington Williams, M.D.
(Date received) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944, at 1 30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 8-27-44

C20267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

C20267 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 Baker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write township and give town)
(d) Street No. 604 ~~Baker St~~ (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Victoria Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife Unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1867

8. AGE: Years 76 | Months 70 | Days 11 | If less than one day hr. min. 24

9. Birthplace Charles Co. Md. (Town, county, and state)

10. Usual Occupation House wk - Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lelia Dobbins
(b) Address 607 Baker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Gutrie
Location West Port

18 (a) Funeral director Sr Brooks
(b) Address 1463 N. Carey St

19 (a) (b) AUG 28 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 19 44, at 930 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 10 19 44 to Aug 26 19 44; and that I last saw h alive on Aug 8 19 44.

Immediate cause of death Cardio Vascular Disease — Duration 5 yrs

Due to Cerebral Hemorrhage — Duration 1 day

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E William Frey
Address 1928 Penna Ave Date signed 8/26/44 M.D.

G20268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20268 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 Cumberland A
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Cumberland A
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Washington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: yes

6 (b) Name of husband or wife Anna Washington
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec 3 - 1873

8. AGE: Years 70 | Months 8 | Days 22 | If less than one day ____hr. ____min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name George Washington
13. Birthplace Md

MOTHER
14. Maiden Name Susan —
15. Birthplace Md

16 (a) Informant Annie Washington
(b) Address 720 Cumberland A

17 (a) [illegible] Burial (b) Date thereof Aug 29 1937
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) AUG 29 1937 (b) Huntington Williamson, M.D.
(Date received) (Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1937, at 2.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1930, to Aug 25 1937, and that I last saw him alive on Aug 5 1937.

Immediate cause of death Cardio Vascular Disease — Duration 7 yrs

Due to Broken Compensation — Duration 6 mo.

Due to — Duration

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E William Frey M. D.
Address 928 Anna An Date signed 8/26/37

G20269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 180

G20269 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) 16 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 N. Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Donald Norwood~~ Michael Donald Hoyle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race Negro

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/21/43

8. AGE: Years 1 | Months 164 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name John Hoyle
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Hazel Norwood
15. Birthplace Ellicott City Md

16 (a) Informant Hazel Norwood
(b) Address 1436 N. Mount St.

17 (a) Burial (b) Date thereof Aug 28-1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1443 N. Carey St.

19 (a) Date received by Local Registrar AUG 28 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-24- 1944, at 10 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
Shock

Due to 2nd & 3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-24-44 at 15/2 9.50 P.M.
(b) Where did injury occur? 1436 N. Biennue
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Conflagration

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-25-44

G20270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20270 Registered No. 171a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Ridgely St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FLOYD HARDY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years	Months	Days	If less than one day
55			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Thomas H. Hardy
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah J. Murry
15. Birthplace Va.

16 (a) Informant Leon Rust
(b) Address Leesburg Va.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Cemetery
Location Leesburg Va.

18 (a) Funeral director J. O. Frederick & Son
(b) Address 1900 Eutaw Pl.

19 (a) 8 28 1944 (b) (Signature of registrar) Clinton Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1944 at 10 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-26-44 at 2:15 P.M.
(b) Where did injury occur? Ridgely & Winchester Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury pedestrian struck by auto

23. Signature H. L. Wollenweber M.D. Medical Examiner.
Date signed 8-27-44

G20271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V83a

G20271 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: 3003
(a) Baltimore City, Maryland
(b) Street address 3003 Kentucky Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Sept 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3003 Kentucky ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Irene Hoover

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Frank Hoover
6 (c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Dec 11 1871
8. AGE: Years 72 Months 8 Days 16 If less than one day ____ hr. ____ min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Staas
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Gordon Hoover
(b) Address 3003 Kentucky ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Herwig Lore
(b) Address 2024 Orleans St.

AUG 28 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1944 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941, to August 26 1944, and that I last saw her alive on August 26 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: Hypertension	15 yrs?
Due to: Arteriosclerosis	15 yrs?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Michael J. Durack M. D.
Address 530 E. Baltimore St. Date signed 8/28/44

G20272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20272 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 18 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ambrose Isaac Ditzler

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Sarah E. Ditzler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10. 1882

8. AGE: Years 67 | Months 2 | Days 17 | If less than one day hr. min.

9. Birthplace Bethel Pa (Town, county, and state)

10. Usual Occupation Bargeman

11. Industry or business R. R. R.

FATHER 12. Name George Ditzler
13. Birthplace Pa.

MOTHER 14. Maiden Name Kate Long
15. Birthplace Pa

16 (a) Informant Helen R. Madden
(b) Address 808 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30, 1944. (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director Mrs. John W. Teufel & Son
(b) Address 1911 W. Fayette St.

19 AUG 28 1944 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944 at 9 55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 15 1943 to Aug 1944, and that I last saw h alive on Aug 27 1944.

	Duration
Immediate cause of death Acute Cardiac Dilatation	2 days
Due to Hypertensive Cardio Vascular Disease	18 Mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 753 N. Fayette St Date signed Aug 28 1944

G20273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G20273 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 ½ Eisden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Spriggs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Spriggs
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary Harris
15. Birthplace Baltimore Md

16 (a) Informant Rose Bunch
(b) Address 115 W Hamilton Street

17 (a) Burial (b) Date thereof Aug 28 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Daniel R Brown Son
(b) Address 1038 W Montgomery Street

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by registrar)

AUG 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-25- 1944, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Advanced Pulmonary Tuberculosis, bi-lateral.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-25-44

G20274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20274 Registered No. 1190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1314 Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Baby Boy Tomlin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1944

8. AGE: Years	Months	Days	If less than one day
		19	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Willis Tomlin
13. Birthplace Lancaster, Pa

MOTHER
14. Maiden Name Mildred Lewis
15. Birthplace Carroll Co. Md.

16 (a) Informant Mildred Tomlin
(b) Address 1314 Bruce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Wm. H. Nelson
(b) Address 1303 Pressman St

19 (a) Date received AUG 28 1944 (b) Registrar Huntington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-26 1944, at 1 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1944 to 8-26 1944, and that I last saw h/ alive on 8-26 1944

Immediate cause of death	Duration
Dehydration	
Cyanosis	
Due to Infections Diarrhea	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. DeLange M. D.
Address Univ. Hosp. Date signed 8-28

G20275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20275

119a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood and Greene St.

(c) Hospital or institution; University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 824 W. Lombard St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Albert Stillings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/19/42

8. AGE: Years	Months	Days	If less than one day
1 2	9	22	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER — 12. Name Albert Stillings

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden Name Mary Sparrow

MOTHER — 15. Birthplace Maryland

16 (a) Informant Mrs. Mary Stillings

(b) Address 824 W. Lombard St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory UNIVERSITY MEDICAL SCHOOL AUG 21 1944

Location

18 (a) Funeral director Commissioner of Health

Address

AUG 28 1944 (b) [signature] Registrar

(Date rec'd by registrar)

VS 150

2113

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/11 1944, at 3:00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/3 1944 to 8/11 1944, and that I last saw him alive on 8/11/1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Malnutrition	
Due to Diarrhea and Dehydration	2 weeks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Dean Bamhal, M. D.

Address Univ. Hosp. Date signed 8/11/44

G20276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

104a

G20276

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4621 Reistertown Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4621 Reistertown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jeanette Armetta

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 21, 1944

8. AGE: Years	Months	Days	If less than one day
		7	hr. min.

9. Birthplace BALTIMORE M.D
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name WILLIAM ARMETTA
13. Birthplace BALTIMORE M.D

MOTHER
14. Maiden Name ANGELA PASTORE
15. Birthplace BALTIMORE MD.

16 (a) Informant MOTHER
(b) Address 4621 REISTERTOWN RD.

17 (a) BURIAL (b) Date thereof AUG. 28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR RD & MORAVIA AVE.

18 (a) Funeral director Frank Della Rocca
(b) Address 57 W. Monroe St Hunterstown, Pa.

19 (a) AUG 28 1944
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1944, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Upper Respiratory Infection

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 8-28-44

G20277

IRA. M. Terrell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20277

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: South Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County Greenville
(c) City or town Greenville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Laurens Road.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Ira M. Terrell

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-24-5039

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Allen Terrell

6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1905

8. AGE: Years 39 | Months 0 | Days 27 23 | If less than one day ..... hr. ..... min.

9. Birthplace Pelzer S.C.
(Town, county, and state)

10. Usual Occupation Store Clerk

11. Industry or business Lebowitz, A.A. Co.

FATHER 12. Name James Plyney Byers

FATHER 13. Birthplace S.C.

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace S.C.

16 (a) Informant Allen Terrell Greenville S.C.

(b) Address 1409 Laurens Rd.

17 (a) Removal (b) Date thereof 8/28/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodlawn Mortuary

Location Green S.C.

18 (a) Funeral director Thomas W. Singleton (R.T.S.)

(b) Address Glen Burnie Md.

19 AUG 28 1944 (Date filed by Registrar) Hunting for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1944, at 11 29 P.M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull - base

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 8-27-44 at ..... P M.

(b) Where did injury occur? Fenhill Rd & Belvedere Rd Balto Co. Md.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Passenger - auto collision

23. Signature Thomas J. Mendes M.D.
Medical Examiner.

Date signed 8-27-44

VS 151

G20278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 93D

Registered No. G20278

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/3/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 8/3/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Dorchester
(c) City or town Cambridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MEREDITH, John William

3 (b) If veteran, name war

3 (c) Social Security Account No. 367-84-20

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1877

8. AGE: Years 67 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Dorchester County, Md.
(Town, county, and state)

10. Usual Occupation Merchant Seaman

11. Industry or business Captain, Barge Airtpin

FATHER
12. Name John M. Meredith
13. Birthplace Dorchester Co., Md.

MOTHER
14. Maiden Name Hester Jane Cannon
15. Birthplace Dorchester Co., Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 44 (month) (day) (year)
(c) Cemetery or crematory
Location Cambridge Md

18 (a) Funeral director Granville J. LeCompte
(b) Address Cambridge Md

19 (Registrar) AUG 28 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH August 27, 1944, at 4:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3, 1944, to Aug. 27, 1944, and that I last saw him alive on Aug. 27, 1944.

Immediate cause of death Arteriosclerotic heart disease with uremia — Duration Unk.

Due to

Due to

Other Conditions Generalized arteriosclerosis; & Secondary anemia

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles W Jones M. D.

Address Baltimore, Md. Date signed 8/28/44

MS-54623

G20279

3 7991

Pineres

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

557

Registered No. G20279

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State So. Amer. (b) County Colombia
(c) City or town Cartagena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Cartagena, Columbia, S.A.

3 (a) FULL NAME Maria Pineres (Maria-de-la-Paz-de-Pineres)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Guillermo Pineres

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 29, 1891

8. AGE: Years 53 | Months 3 | Days 28 | If less than one day hr. min.

9. Birthplace S. A. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Adolf Pineres (col. S. A.)
13. Birthplace

MOTHER
14. Maiden Name Juana Fuenpalacios (col. S. A.)
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway

AUG 28 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27- 1944, at 9 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19-1944 to 8-27-1944 and that I last saw her alive on 8-27-1944.

Immediate cause of death Respiratory Failure

Due to Carcinoma of antrum, left, c intracranial extension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. S. Sprague III M. D.
Address Johns Hopkins Hosp. Date signed 8-27-44

G20280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 104

G20280 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 Lemon Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 Lemon Street
(If rural give location)
(e) Citizen of foreign country? Common (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Cook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hester Cook

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Henry Cook
(b) Address 1517 Lemon Street

17 (a) (Burial, cremation, or removal) (b) Date thereof Aug 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Katie A. Wilkes
(b) Address 332 N. Schroeder St.

19 (a) AUG 28 1944 (Date rec'd by registrar) (b) Registrar

VS 150

Huntington Williams, MR

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 24 1944, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1944 to 8/24 1944, and that I last saw him alive on 8/22 1944.

Immediate cause of death: Pneumonia (Lobar)

Due to: Exposure, infection, malnutrition

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Wm. A. Wilkes, M.D.

Address 21 N. Gilmor St. Date signed 8/28/44

G20281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G20281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 Foster Ave
(c) Hospital or institution:
3320

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3320 Foster Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALOYSIUS VOGEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 6 1890

8. AGE: Years	Months	Days	If less than one day
54	0	18	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation BOX MAKER

11. Industry or business

FATHER
12. Name ADAM VOGEL
13. Birthplace GERMANY

MOTHER
14. Maiden Name ?
15. Birthplace GERMANY

16 (a) Informant SEBASTIAN VOGEL
(b) Address 3320 FOSTER AVE.

17 (a) Burial (b) Date thereof 8/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Lill & Gilmor Sts
18 (a) Funeral director Belair Rd
(b) Address 403 S. Wolfe St
19 (a) 8-28-1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 19 44 at 6 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Attending Medical Examiner.
Date signed 8-27-44

G20282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G20282 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 N.ROSE ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 N.ROSE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MADALENA CLARK

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife WALTER C.CLARK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) APR.12 1898

8. AGE: Years	Months	Days	If less than one day
46	4	14	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name JOHN PRASCH
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name CAROLINA KELLER
15. Birthplace BALTO.MD.

16 (a) Informant WALTER C.CLARK(HUSBAND)
(b) Address 222 N.ROSE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG.30/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Zeller Sons
(b) Address 403 S.WOLFE ST.

19 (a) AUG 28 1944 Registered by me Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG.26 1944 at 8/50 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1944 to 8/26 1944 and that I last saw h— alive on 8/26cc 1944.

Immediate cause of death Pneumonia
Acidemia

Due to Myocardial decompensation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Taubman M. D.
Address 100 N. Milton Av Date signed 8/28/44

G20283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20283 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 421 S. Washington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 S. Washington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Schweiger

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 216-16-2417

4. Sex: M.

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 9 1884

8. AGE: Years	Months	Days	If less than one day
59 60.	8	18	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name VALENTINE SCHWEIGER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ELIZABETH DUNKEN
15. Birthplace BALTO. MD.

16 (a) Informant ELIZABETH CONROY (NEICE)
(b) Address 421 S. WASHINGTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof AUG. 30/44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly and Geiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1944, at 5:00 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 8/29/44

G20284

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20284
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 807. N. Streeper. St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 807. N. Streeper St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christopher L. Hamico

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Infant.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28. 1944.

8. AGE: Years	Months	Days	If less than one day
		2.	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Infant.
11. Industry or business

FATHER
12. Name Joseph Hamico
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna Page
15. Birthplace Baltimore Md.

16 (a) Informant Joseph. Hamico
(b) Address 807. N. Streeper St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 28. 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road.

18 (a) Funeral director Wendell Hoppel
(b) Address 312 S. Highland Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-44 at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24-44 to 8-27-44
and that I last saw h alive on 8-27-44

Immediate cause of death	Duration
Premature Birth	2 Day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thea Rugby M. D.
Address Baltimore Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8-30a

G20285 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2911 White Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 White Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frances Meshane

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 30 1865

8. AGE: Years 57 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Bro. R.R. (Clerk)

11. Industry or business

FATHER 12. Name George Kuhn

13. Birthplace Germany

MOTHER 14. Maiden Name Kunigonda Eberlein

15. Birthplace Germany

16 (a) Informant Mrs Louise A. Weaver

(b) Address 3417 Noble St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location

18 (a) Funeral director L. J. Ruck

(b) Address 5305 Harford Rd

AUG 28 1944 Huntington-Williams, Mgr.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 25 1944, at 12:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July - 1941, to Aug - 25 1944, and that I last saw h[illegible] alive on Aug - 25 1944.

Immediate cause of death Cerebral Hemorrhage. — Duration

Due to Hypertension and Arteriosclerosis. —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. B. Boyle —
Address 521 - Harford Rd. Date signed 8/26/44 (Dr.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

G20286 Registered No. 9

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: U. M. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ~~Baltimore~~ Parkville
(c) City or town ~~Baltimore~~ (If outside city or town limits, write RURAL and give town)
(d) Street No. 4035 Roland Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Baby Boy McKenzie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-44.

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Charles McKenzie
13. Birthplace Baltimore

MOTHER
14. Maiden Name Lillian Reisz
15. Birthplace Baltimore

16 (a) Informant History.
(b) Address —

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-28-44 (month) (day) (year)
(c) Cemetery or crematory Morland Cem.
Location

18 (a) Funeral director L. J. Rusk
(b) Address 630 S. Rayland Rd.

AUG 28 1944 (b) Registrar
Date received by Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944, at 11:17 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1944 to Aug 27 1944, and that I last saw h~~im~~ alive on Aug 27 1944.

Immediate cause of death: Congenital atelectasis — Duration

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature John G. Lawrence Jr. M.D.
Address 9 E. Chase St. Date signed Aug 27 44

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G20287

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 das
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Bellona Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRIET HALL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30-1865

8. AGE: Years 79 | Months 1 | Days 26 27 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Fusselbaugh
15. Birthplace Maryland

16 (a) Informant Mrs. Wm. C. Fraser
(b) Address 2624 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director H. W. Meamston
(b) Address 805 Calvert St.

19 (a) AUG 28 1944 (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944 at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to Fracture of left femur

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/12

(a) Date of injury 8-9-44 at M.
(b) Where did injury occur? alone at home
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury slipped & fell in bathtub

23. Signature H. W. Williamson M.D. Medical Examiner.

Date signed 8-27-44

C20288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. C20288

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A
(b) Street address 1227 E. Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days) 67 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace J. McNulty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Henry McNulty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29-1876

8. AGE: Years 67 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Benjamin F. Jones
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary J. Wilcox
15. Birthplace Baltimore, Md

16 (a) Informant Miss Grace Jones
(b) Address 1220 E. North Ave

17 (a) Burial (b) Date thereof 8/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meerstone
(b) Address 805 N. Calvert St.

19 (a) AUG 28 1944 Hunter for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 19 44, at 1-15 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Carcinoma of Cervix Uteri
c Metastases

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Charles J. Finnimore M.D.
Medical Examiner.
Date signed 8/29/44

G20289 - Penal

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G20289

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3949 Roland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3949 Roland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Albert L. Schriver.

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 12, 1897

8. AGE: Years	Months	Days	If less than one day: hr.	min.
47	1	9		

9. Birthplace Maryland (State, county, and state)
10. Usual Occupation Painter.
11. Industry or business

FATHER
12. Name Lewis C. Schriver.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Estelle Schisler.
15. Birthplace Maryland

16 (a) Informant Frederick S. Johnson
(b) Address 4605 Belmont Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Robert Lowell & Sons
(b) Address 3615-17 Eastern Ave.

19 (a) (b) Registrar Huntington Williams, M.D.

AUG 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1944 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Aug 26 1944 and that I last saw him alive on Aug 26 1944.

Immediate cause of death: Coronary Occlusion

Due to: Coronary Thrombosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? at M (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. L. Harsman M. D.
Address 4037 Falls Rd. Date signed 8/28/44

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G20290

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore
(c) Hospital or institution: 2002 E. 30th. St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-16
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 E. 30th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Caroline M. Kauffman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	Married

6 (b) Name of husband or wife Chester A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2. 1884

8. AGE: Years	Months	Days	If less than one day
60	3	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frederick Linck
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. W. Allen Gettemuller
(b) Address 2002 E. 30th St. Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) Date received AUG 28 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 1944, at 3:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1943, to Aug 26 1944 and that I last saw h[illegible] alive on Aug 27 1944.

Immediate cause of death: Acute Coronary Occlusion — Duration: 1 day
Due to: Arteriosclerotic Heart Disease — Duration: 5 years
Due to:
Other Conditions: Hemiplegia (R.) Essential Hypertension
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. Dawson M. D.
Address 4808 Halford Rd. Date signed 8/28/44

G20291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938

G20291 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2601 Keyworth Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2601 Keyworth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Alfred Bradfield

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26. 1877

8. AGE: Years 66 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Frankford, Pa.
(Town, county, and state)

10. Usual Occupation Retired Furniture Salesman

11. Industry or business

FATHER
12. Name Henry Bradfield
13. Birthplace Abingdon Township Pa.

MOTHER
14. Maiden Name Mary Hutchins
15. Birthplace Abingdon Township Pa.

16 (a) Informant Mrs. Gertrude Bradfield
(b) Address 2601 Keyworth Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pa. Aves.

19 AUG 28 1944 (Date received by Registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1944, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1941, to Aug 27 1944.
and that I last saw h. l. alive on Aug 27 1944.

Immediate cause of death Hypertension
C V D. with Angina Pectoris

Duration: 3

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Lawrence Shimanek M. D.
Address 3711 Dalrd Date signed 8-28-44

SHIMANEK

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G20292

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3126 Sequoia Ave
(c) Hospital or institution: D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3126 Sequoia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence E. Hensel

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Henry H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 20 1871

8. AGE: Years	Months	Days	If less than one day
73	0	7	hr. min.

9. Birthplace Germantown Pa.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Stratton Burgess
13. Birthplace Germantown Pa.

MOTHER
14. Maiden Name Emma Mann
15. Birthplace Pa.

16 (a) Informant Mr. H. Howard Hensel
(b) Address 3126 Sequoia Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) AUG 29 1944 (Date rec'd by registrar) Washington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1944, at 9 00 A M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V. Disease
Senility

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester J. Sabinski M.D.
Medical Examiner.
Date signed 8/29/44

G20293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No. G20293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3405 Grantley Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Abe Schwartz

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09- 3102

4. Sex male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/12/1895

8. AGE: Years 49 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace New Brunswick N. J. (Town, county, and state)

10. Usual Occupation Buyer

11. Industry or business Julius Gutman & Co

FATHER
12. Name Leon Schwartz
13. Birthplace Roumania

MOTHER
14. Maiden Name Bessie ?
15. Birthplace Roumania

16 (a) Informant Anna Schwartz
(b) Address 3405 Grantley Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

AUG 28 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1944, at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1944 to 8/27 1944 and that I last saw him alive on 8/27 1944.

Immediate cause of death Myocardial failure — Duration

Due to Coronary occlusion

Due to Hypertensive arteriosclerotic heart disease

Other Conditions Ht. incarcerated inguinal hernia

(Include pregnancy within 3 months of death)

Date of operation 8/27/44

Major findings of operation: Ht. incarcerated inguinal hernia

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Aaman M. D.
Address Sinai Hosp. Date signed 8/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARCHANT CALENDAR SYSTEMS, INC. ALL RIGHTS RESERVED FOR BINDING

G20294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G20294 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Emmitsburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sister Patricia Malloy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Religious

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant St. Agnes Hospital

(b) Address Caton + Wilkens Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/30/44 (month) (day) (year)

(c) Cemetery or crematory St Joseph

Location Emmitsburg Md.

18 (a) Funeral director Martin Gehrdstone

(b) Address 1827 W. North Ave

19 (a) (Registrar) (b) Huntington Williams, M.D.

AUG 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1944, at 3:4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1944 to 8/28 1944.
and that I last saw her alive on 8/28 1944

Immediate cause of death: Heart Failure

Due to: Cardio-renal disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work)
(e) Means of injury

23. Signature F. J. Raffucci M.D. M. D.

Address St. agnes Date signed 8/28/44

620295 BALTIMORE CITY HEALTH DEPARTMENT 620295
CERTIFICATE OF DEATH 59

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Marlla Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Manner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/23/44

8. AGE: Years	Months	Days	If less than one day
			1/2 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER	12. Name John Manner
	13. Birthplace Balto. Md.
MOTHER	14. Maiden Name Nancy Kelly
	15. Birthplace Balto. Md.

16 (a) Informant Mrs Nancy Manner
(b) Address 5304 Marlla Rd Balto, Md
17 (a) Burial (b) Date thereof 8-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Govans Md
18 (a) Funeral director Gary-Hopkins
(b) Address Fulton & Presstman
19 (a) AUG 28 1944 (b) Huntington Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/23 1944 at 5-30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1944, to 8/23 1944, and that I last saw h[illegible] alive on 8/23 1944

Immediate cause of death	Duration
Premature 23-26 Weeks.	
Due to Miscarriage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Sigika M. D.
Address Mercy Hospital Date signed 8/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20296 Registered No.

46a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Fort Howard
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Diduch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 1892

8. AGE: Years	Months	Days	If less than one day
52	4	8	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Kitchen Helper
11. Industry or business

FATHER
12. Name John Diduch
13. Birthplace Austria

MOTHER
14. Maiden Name Magdalene Sapetok
15. Birthplace Austria

16 (a) Informant Dept Record
(b) Address

17 (a) Burial (b) Date thereof 8-25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Guy A Bailey
(b) Address Fulton & Lexington Sts

19 (a) [illegible] (b) [illegible]
(City or town) (County) (State) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1944 at 12 20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1944 to Aug 22 1944 and that I last saw him alive on Aug 22 1944

Immediate cause of death: cachexia — Duration

Due to: Carcinoma of esophagus

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 8/14/44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature J A Gaughen M.D.
Address Mercy Hosp Date signed 8/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G20297
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address University Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 912 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Snow

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1944

8. AGE: Years | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Kingstree South Carolina
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Walter Snowden
13. Birthplace Kingstree So Carolina

MOTHER
14. Maiden Name Mary Sulton
15. Birthplace Kingstree So Carolina

16 (a) Informant Mrs. Snowden
(b) Address 912 Warner Street

17 (a) Burial (b) Date thereof August 29 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Auburn
Location Baltimore City Md.

18 (a) Funeral director Joseph G. Lucky
(b) Address 710 South Mount Street

AUG 28 1944 (b)
(Local registrar) Registrar

VS 180

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1944, at 4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-25 1944, to 8-28 1944, and that I last saw h.C.T alive on 8-28 1944.

Immediate cause of death	Duration
Toxemia	
Due to Infections Diarrhea	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Range M. D.

Address Mercy Hosp. Date signed 8-28-

G20298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97 Registered No. G20298

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6015 Sycamore Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 86 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 6015 Sycamore Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Alice Maud Hopkins
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Deceased. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov 28 1857
8. AGE: Years 86 Months 8 Days 29 If less than one day hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Edwin Weaver
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Abigail Ann Mosher
15. Birthplace

16 (a) Informant Mrs Sarah Edith Hopper
(b) Address 6015 Sycamore Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 29/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn Md

18 (a) Funeral director John C Yoran
(b) Address 3600 E Baltimore St

19 (a) Huntington Williamson, M.D. (b) Date received AUG 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1944, at 11.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1944 to Aug. 26 1944, and that I last saw h[illegible] alive on August 23 1944.

Immediate cause of death: Auricular Fibrillation — Duration: 6 months
Due to:
Due to:
Other Conditions Arteriosclerosis & Varicose Ulcer
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eldred Roberts M.D.
Address 6100 York Road Balto Md Date signed 8-26-44 M. D.

G20299 X ✓ G20299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52a

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/16/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/16/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Mich. (b) County
(c) City or town Grand Haven (If outside city or town limits, write RURAL and give town)
(d) Street No. 856 Harbor Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HOWELL, Carl Eugene

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Virgie?
6 (c) If alive, give age 52 years
7. Birth date of deceased (mo., day, yr.) Nov. 25, 1890
8. AGE: Years 53 | Months 9 | Days 2 | If less than one day ____ hr. ____ min.
9. Birthplace Mich. City, Indiana (Town, county, and state)
10. Usual Occupation CG (WO) Warrant Boatswain
11. Industry or business C.G.Life Boat Sta. Chicago, Ill.

FATHER
12. Name Charles Howell
13. Birthplace ?

MOTHER
14. Maiden Name Margaret Johnson
15. Birthplace ? Indiana

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Chicago Ill.

18 (a) Funeral director Rothe & B.M. Walters
(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by registrar) Huntington Williams M.D.
AUG 28 1944

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 27, 1944, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16, 1944 to Aug. 27, 1944, and that I last saw him alive on Aug. 27, 1944

Immediate cause of death: Terminal bronchial pneumonia — Duration: 1 week

Due to: Adenocarcinoma of right kidney with multiple metastases — First noticed 12/1943

Due to: Any

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward L. Jones
Address Baltimore, Md. Date signed 8/28/44

54203

G20300

BALTIMORE CITY HEALTH DEPARTMENT X G20300

CERTIFICATE OF DEATH 46 H

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/20/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/20/44

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town USCG Rockaway LB Sta.
(If outside city or town limits, write RURAL and give town)
(d) Street No. New York
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME DAVID HARRY RAEL Home Add: 27 E. Park St., Long Beach, N. Y.

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1900

8. AGE: Years 43 | Months 9 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation RT 1/c

11. Industry or business Coast Guard

FATHER
12. Name Samuel Rael
13. Birthplace England

MOTHER
14. Maiden Name Bertha Gottlieb
15. Birthplace Austria

16 (a) Informant Records U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug (month) 1944 (day) (year)

(c) Cemetery or crematory Location New York N.Y.

18 (a) Funeral director Robt C. & B.M. Walters

(b) Address Fath. Steiker ... Huntington Williams, Md.

AUG 2 8 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH August 28, 1944, at 4:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 20, 1944, to Aug. 28, 1944 and that I last saw him alive on Aug. 28, 1944.

Immediate cause of death Retroperitoneal lymphosarcoma with metastasis — Duration Aug. 1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation?

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles to Jones
Address Baltimore, Md. Date signed 8/28/44

CG-54311

G20301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G20301
Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1817 Westfield St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1817 Westfield St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J. TOLSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Laura J. (Mrs Rollins)
6 (c) If alive, give age 85 years

7. Birth date of deceased (mo., day, yr.) Dec 1-1856

8. AGE: Years	Months	Days	If less than one day
87	10	27	hr. min.

9. Birthplace Balto. Md
(Town, county, and state)
10. Usual Occupation Boiler maker
11. Industry or business Retired

FATHER
12. Name William Tolson
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Rebecca Meads
15. Birthplace Balto Md

16 (a) Informant Mrs Ges Bennett
(b) Address Cambridge Md

17 (a) Burial (b) Date thereof Aug 31-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenlawn Cem
Location Cambridge Route 3

18 (a) Funeral director Asmyth & Le Compte
(b) Address Cambridge Md

19 (a) AUG 29 1944 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28, 1944, at 10 30 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence
(Autopsy or Inquiry)
obtained by said " find that said deceased came
(Autopsy or Inquiry)
to his death on the day stated above.

Immediate cause of death	Duration
Arteriosclerosis	
cardiovascular	
Due to disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 8-28-44

G20302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

✓ G20302 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1227 E. Madeira St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1227 E Madeira St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nola Griffin
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 24 1881

8. AGE: Years 62 Months 8 Days 3 If less than one day hr. min.

9. Birthplace S. Carolina
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Jenkins
13. Birthplace S. C.

MOTHER
14. Maiden Name Aggie Oliver
15. Birthplace S. C.

16 (a) Informant Jeanette Allen
(b) Address 1227 E. Madeira St

17 (a) Removal (b) Date thereof Aug 30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location St. George's Carolina

18 (a) Funeral director Mrs. Robert O. Elliott, Jr.
(b) Address 1129 N. Carlisle St.

19 (a) AUG 28 1944 (b) Registrar
(Date accepted by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1944 11:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 21 1944 to Aug 27 1944 and that I last saw h[illegible] alive on Aug 24 1944

Immediate cause of death	Duration
Cerebral thrombosis	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Turnbull M. D.
Address 1422 E. Chase Date signed 8-29-44

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

20303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46d ✓

G20303 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1705- Crystal Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1705- Crystal Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph E. Guy.
3 (b) If veteran, name war
3 (c) Social Security Account No. 712-07-6286
4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Minnie Guy.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept 17-1896
8. AGE: Years 47 | Months 11 | Days 22 | If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Undertaker.
11. Industry or business Funeral Parlor.
FATHER 12. Name Dixon Guy.
13. Birthplace Baltimore
MOTHER 14. Maiden Name Margaret Pierce
15. Birthplace Baltimore
16 (a) Informant Mrs Minnie Guy.
(b) Address 1705- Crystal Ave
17 (a) Burial (b) Date thereof 8-29-44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Baltimore.
Location 2 North Avenue
18 (a) Funeral director Kimball & Hunt Sons
(b) Address 1501 N Broadway.
19 AUG 29 1944 (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1944 at 4 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944 to Aug 26 1944 and that I last saw him alive on Aug 26 1944

	Duration
Immediate cause of death Carcinoma of Rectum	1 year
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature George Dawson, M.D.
Address 4808 Harford Rd Date signed 8/28/44

VS 180

G20304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G20304

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKING RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Rutland Ave
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL R RIFKIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Widowed

6 (b) Name of husband or wife Jennie M.

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65			hr. min.

9. Birthplace Staten Island N. Y.
(Town, county and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant James K. Rifkin
(b) Address 103 Talbot Rd. Chatt. Tenna

17 (a) Removal (b) Date thereof 8-28-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Staten Island N. Y.

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1469 E Baltimore St

19 AUG 29 1944 Hampton Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1944, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1944, to 8-28 1944, and that I last saw h.was alive on 8-28 1944.

Immediate cause of death
Coronary Thrombosis
Due to Hypertension Chronic Heart Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Meisels M. D.
Address Sinai Hosp. Date signed 8-28-44

Dr. Franklin 1123 St. Paul St. VE 0078-5588

G20305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G20305

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 401 Pittman Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Pittman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert S. Fockler

3 (b) If veteran, name war W

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Sarah A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4th 1884

8. AGE: Years 60 | Months 6 | Days 22 | If less than one day hr. min.

9. Birthplace Snyder Co., Pa (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business Self

FATHER
12. Name John Fockler
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Ryan
15. Birthplace Pa.

16 (a) Informant Mrs. Sarah A. Fockler
(b) Address 401 Pittman Place

17 (a) Burial (b) Date thereof 8/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 AUG 29 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-23 1944 to 8-26 1944, and that I last saw him alive on 8/26 1944.

Immediate cause of death Myocardial failure

Due to Hypocondiac Chronic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Franklin M.D.
Address 1123 St Paul St Date signed 8/29/44

H.D. Franklin

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G20306 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1719 E Fidual St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore A Fleischman

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife: Fannie G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5. 1871

8. AGE: Years 73 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace Md (City, county, and state)

10. Usual Occupation Retired

11. Industry or business

MOTHER / FATHER
12. Name Unknown Fleischman
13. Birthplace Germany
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Catherine Bathus
(b) Address 1719 E Fidual St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-29-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Wilson Bros Inc
(b) Address 1217 E Fayette St

19 (a) [illegible] (b) Date received AUG 29 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944 at 5 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 5, 1944 to Aug 27, 1944. and that I last saw him alive on Aug. 27, 1944.

Immediate cause of death: Carcinoma of the liver — Duration: 4 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen G Singewald
Address 1613 E. North Ave. Date signed 8-28-44

G20307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G20307
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Hubert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dorthy Dunbar

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: 20AF

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 24 1923

8. AGE: Years 10 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None
11. Industry or business

FATHER
12. Name Wilborn Dunbar
13. Birthplace England

MOTHER
14. Maiden Name Thelma Cole
15. Birthplace Baltimore Md

16 (a) Informant Wilborn Dunbar
(b) Address 3010 Hubert St

17 (a) Burial (cremation or removal)
(b) Date thereof 8/31/44 (month) (day) (year)
Cemetery or Crematory Loudon Park
Location Frederick Road Baltimore Md

18 (a) Funeral director Williams Funeral Home
(b) Address 1219 E Fort Ave

19 (a) (Date received by local registrar) AUG 29 1944 (b) Signature of registrar for Williams, M.D.

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1944 at 11:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1944 to 8/28 1944 and that I last saw her alive on 8/28 1944

Immediate cause of death	Duration
Acute Dilatation of Stomach	
Due to Obstruction due to	
Due to Paralytic Ileus	
Other Conditions Diabetes ? Severe Pneumonia (Include pregnancy within 3 months of death)	

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature Evelyn Simmons
Address 1219 E Fort Ave (Date signed) 8/31/44

G20308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1420 Registered No. G20308

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Bradford Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

7-3

3 (a) FULL NAME Bessie Billy

9 107450 7451

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nathaniel Billy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14-1910

8. AGE: Years 33 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Robinson
13. Birthplace N.C.

MOTHER
14. Maiden Name Mary Bennett
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 31 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Brooklyn Md

18 (a) Funeral director Mrs Ida Baffy
(b) Address 1424 Jefferson St Huntington Williams, Md.

19 (a) AUG 29 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27- 1944, at 10.15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19- 1944, to 8-27- 1944, and that I last saw her alive on 8-27- 1944

Immediate cause of death Terminal Broncho-Pneumonia
Post-Partum Hemorrhage, 6 Days — Duration 1 Day
Due to Abdominal Pregnancy
Due to
Other Conditions Endometritis Puerperium
Preg. Termination Uterine evac
(Include pregnancy within 3 months of death)
Date of operation 8/24/44
Major findings of operation: [redacted] Abdominal Preg.
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. Donaldson Jr. M.D.
Address BCH Date signed 8/29/44

G20309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 10 S. Patterson Pk. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 S. Patterson Pk. Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonina Dyszynski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Karol

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business At Home

FATHER
12. Name Casimir Dziedzic
13. Birthplace Poland

MOTHER
14. Maiden Name Teofila Vauldich
15. Birthplace Poland

16 (a) Informant Tillie T. Ozazewski
(b) Address 1930 Eastern Ave.

17 (a) Burial (b) Date thereof Aug. 31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director F W Ozazewski
(b) Address 1930 Eastern Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

AUG 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1944, at 6.48 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1940, to Aug. 27 1944, and that I last saw her alive on Aug. 27 1944

Immediate cause of death	Duration
Due to Cerebral Apoplexy	6 mos
Due to Cerebral Arteriosclerosis	?
Due to Chr. Hypertension	?
Due to Cardio-vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary J. Dziedzic M. D.
Address 1930 E. Baltimore Date signed 8-29-44

G20310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1240 Registered No. G20310

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 608 S. Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NINA MARY SCHAFFER OR SHAFFER

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James B. Schaffer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years 56? | Months | Days | If less than one day hr. min.

9. Birthplace New York (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mr James B. Schaffer

(b) Address 608 S. Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 29-44 (month) (day) (year)

(c) Cemetery or crematory Holy Trinity Ruppersburg

Location Stoney Run Ave Brooklyn Md

18 (a) Funeral director John A. Grebliunas Sons

(b) Address 423 S. Foca St

19 (a) AUG 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 26 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma, genital, cervix

Due to Chronic alcoholism

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

Did injury occur at home, on farm, industrial place, in public place? While at work?

Means of injury

23. Signature H. Z. Wallenmeyer M.D. Medical Examiner.

Date signed 8-29-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G20311 P.O.A.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G20311

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 21 S. Kinsman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Jackie Sifford
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/44

8. AGE: Years	Months	Days	If less than one day
0	6	28	hr. min.

9. Birthplace Baltimore (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Sifford
13. Birthplace Md.

MOTHER
14. Maiden Name Merle T. Bullock
15. Birthplace Ga

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Hornig Stand
(b) Address 2024 Orleans St

AUG 29 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 1944, at 5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1944, to Aug. 25 1944, and that I last saw him alive on Aug. 25 1944.

Immediate cause of death	Duration
Dehydration	
Due to acute nutritional disturbance	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lucius R. Lindley M. D.
Address J. H. H. Date signed 8/28/44

G20312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43d

G20312 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 44 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Ashburton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy E. Dwyer

3 (b) If veteran, name war ----

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race Wht.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John C. Dwyer

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 15, 1869

8. AGE: Years 75 | Months 2 | Days 12 | If less than one day ... hr. ... min.

9. Birthplace Elkridge Md.
(Town, county, and state)

10. Usual Occupation House-Wife

11. Industry or business --

FATHER
12. Name John Riley
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Neucoper
15. Birthplace Holland

16 (a) Informant John C. Dwyer
(b) Address 603 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Balto. Co. Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) AUG 29 1944 (b) Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1936 to Aug 27 1944 and that I last saw h[illegible] alive on Aug 27 1944

Immediate cause of death: Hypertensive Cardio Vascular Disease — Duration 10 yrs
Due to: Essential Hypertension. — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Albert Dinehart M.D.
Address 2302 Edmondson Ave Date signed 8/28/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Date of death and correct age is especially important.

MARGIN RESERVED FOR BINDING

G20313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 932

X ✓ G20313 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Hyde, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Christian Florence Bond

3 (b) If veteran, name war: --

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife: Walter Bond
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8, 1875

8. AGE: Years	Months	Days	If less than one day
68	8	19	hr. min.

9. Birthplace -- (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Bay
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Walter Bond
(b) Address Hyde, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/44 (month) (day) (year)
(c) Cemetery or crematory Fork M. E. Cem.
Location Fork, Md.

18 (a) Funeral director C. E. ARTHUR
(b) Address Fork, Md.

19 (a) (Registrar) (b) Huntington Williams, M.D. Registrar

AUG 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1944, at 8 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1944 to 8/27 1944 and that I last saw h[er] alive on 8/27 1944

Immediate cause of death	Duration
Cerebro Vascular Accident	
Due to Hypertensive Cardio Vascular Disease	
Due to	
Other Conditions Partial Paralysis from stroke 2 yrs ago. Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Thelma J. Jamonkis M.D.
Address Dr Jordan Hyde Date signed 8/29/44

G20314

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

G20314 A
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6202 Marbuth Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Elizabeth Von Munchow

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Rudolph C
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 14, 1855

8. AGE: Years 88 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Co Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Ulrich
13. Birthplace Germany.

MOTHER 14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Mrs Fulton Wilson
(b) Address 2913 Juniper St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Fulton & Wilson Inc
(b) Address 1219 St Paul St

29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1944. at 12 25 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 29 1944 to Aug 28 1944. and that I last saw her alive on Aug 28 1944.

Immediate cause of death	Duration
Myocardial	3 hours
Due to Hypostatic pneumonia	
Due to Arterio-Sclerosis	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Bacon M. D.
Address 100 Cathedral Date signed 8/30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

RESERVED FOR BINDING

VS 150

G20315

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G20315 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly. ALL ENTRIES TO BE TYPED OR WRITTEN IN INK. SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 738 E 30th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 738 E 30th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie Peckham

3 (b) If veteran, name war: W
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Lewis H
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7 1884
8. AGE: Years 60 | Months 4 | Days 21 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Lemuel Moffitt
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Chapman
15. Birthplace Md

16 (a) Informant Louis H Peckham
(b) Address 521 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md

18 (a) Funeral director Milton Lee Sons
(b) Address 1917 E Pratt St

19 (a) (Date rec'd by registrar) AUG 29 1944 Washington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1944 at 5 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 19XX to Aug 28 19XX and that I last saw h[illegible] alive on Aug 28 19XX

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to	
Due to Pernicious Anemia	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1520 E 33rd Date signed 8/29/44

V8 150

G20316

AB-89514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1244

Registered No. G20316

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write to the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 25yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 West Montgomery St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Foster

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1897

8. AGE: Years 46 | Months 4 ? | Days 0 | If less than one day ... hr. ... min.

9. Birthplace Alabama
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charlie
13. Birthplace Alabama

MOTHER 14. Maiden Name Nancy ?
15. Birthplace Alabama

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (b) Date thereof 8/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A 4 W Mct

18 (a) Funeral director Jacob L. Brown & Son
(b) Address 1018 W Montgomery St.

19 AUG 29 1944 (b) Huntington Williams M.D.
(Date received by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25- 1944, at 8.40PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1944, to 8-25- 1944, and that I last saw him alive on 8-25- 1944

Immediate cause of death Circ. of liver — Duration

Due to

Due to

Other Conditions Uremia; secondary anemia; cystitis; diabetes ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: no post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. O. Berry Jr. M.D.
Address City Hosp. Date signed 8/29/44

G20317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20317 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Bethune
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 Wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Havre de Grace
(If outside city or town write RURAL and give town)
(d) Street No. 312 No Stokes St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Albert Joseph Bennett

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 28, 1874

8. AGE: Years	Months	Days	If less than one day
70	4	30	hr. min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Retired U.S. Gov.

FATHER
12. Name Joshua Bennett
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ely Bennett
15. Birthplace Md.

16 (a) Informant Mrs. Virginia E. Paul
(b) Address 1706 Hatem Ave Balto

17 (a) Burial (b) Date thereof Aug 30 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery Aug 30th 1944
Location Pikesville Md.

18 (a) Funeral director Magruder Mitchell
(b) Address Havre de Grace, Md.

19 (a) AUG 29 1944 (b) Huntington Williams M.D.
(Registrar's signature)
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21, 1944, to 8-27, 1944, and that I last saw him alive on 8-27 1944.

Immediate cause of death	Duration
Chronic Myocardial Degeneration	1 yr.
Due to Arteriosclerosis	17+
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. R. Pollard M. D.
Address 307 E. Fort Ave. Date signed 8-27-44

G20318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G20318 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3302 Ellerslie Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3302 Ellerslie Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles W. Klein

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marjorie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1st, 1900

8. AGE: Years	Months	Days	If less than one day
43	8	26	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Durafley Corp.

FATHER
12. Name Wilfred Klein
13. Birthplace Maryland

MOTHER
14. Maiden Name Maud A. McComas
15. Birthplace Maryland

16 (a) Informant Mrs. M. Klein
(b) Address 3302 Ellerslie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-30th 1944 (month) (day) (year)
(c) Cemetery or crematory Newkatheridal
Location Edmondson Ave
18 (a) Funeral director Leo S. Brook
(b) Address 1720 W. Patterson Park Ave

19 (a) AUG 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 1944 at 4:40 A.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
By Robert Lee Medical Examiner M.D.
Date signed Aug. 29 1944

G20319 BALTIMORE CITY HEALTH DEPARTMENT 163 H G20319

CERTIFICATE OF DEATH

Registered No.

Formerly at 605 Park ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 500 Campbell Lane
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Dorman

3 (b) If veteran, name war: WAC WORLD WAR II
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	MARRIED

6 (b) Name of husband or wife: JOHN DORMAN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 6 - 1903

8. AGE: Years	Months	Days	If less than one day
40	31	21	hr. min.

9. Birthplace BALTIMORE MD
(Town, county, and state)
10. Usual Occupation EXAMINERS UNEMPLOYMENT
11. Industry or business BUREAU STATE OF MD

FATHER
12. Name JEREMIAH A. LYNCH
13. Birthplace MARYLAND

MOTHER
14. Maiden Name MARGARET A SULLIVAN
15. Birthplace

16 (a) Informant JOHN DORMAN
(b) Address 3133 E MONUMENT ST

17 (a) BURIAL (b) Date thereof 8 30 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ST. FRANCIS
Location ARLINGTON MD

18 (a) Funeral director Chas. J. Eggard Sons
(b) Address 118 W. Mt. Royal Ave

19 (a) AUG 29 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27-1944, at 6 P. M

21. I certify that I took charge of the remains described above, held an Autopsy-Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Asphyxiation

Due to: Illuminating Gas

Other Conditions: Despondent

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-27-44 at P. M.
(b) Where did injury occur? 605 Park ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled 3 gas burners
(e) Signature Howard J. Waldeck M.D.
Medical Examiner.
Date signed 8-28-44

G20320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20320

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 S. Greene
(c) Hospital or institution Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 44yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 707 Ramsay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles G. Kraft.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1939

8. AGE: Years 4 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward J. Kraft.
13. Birthplace Md.

MOTHER
14. Maiden Name Fannie Ewing
15. Birthplace Md.

16 (a) Informant Kraft
(b) Address 707 Ramsay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Mem. Cem.
Location

18 (a) Undertaker Geo. H. Lyerly
(b) Address 125 N. Eutaw St.

19 (a) AUG 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28-44 19 , at 12 40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27-44 19 , to 8-28-44 , and that I last saw h. alive on 8-28-44

Immediate cause of death Peripheral vascular collapse — Duration

Due to Klebsiella-Friedländer Syndrome

Due to Meningococcic Septicemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunter Pearl, M.D. M. D.

Address Univ. Hosp. Date signed 8-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G20321

G20321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1615 Parkwood
(c) Hospital or institution The Baptist Home 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Parkwood
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Miss Louise Ophelia Richardson

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May-27-1860

8. AGE: Years 84 | Months 3 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Samuel Richardson
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Marilla Miller
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Lafeuver (niece)
(b) Address 1081 W. University Pky

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8-31-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Stewart & Mourning Co.
(b) Address 1010 N. Eutaw St.

AUG 29 1944 (Date received by registrar) (b) Hunting Van Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1944 at 3 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1944 to Aug 28 1944, and that I last saw her alive on Aug 29 1944

Immediate cause of death	Duration
Thrombosis of Cerebral Vessels	8 d.
Due to Renal Insufficiency.	72 hrs
Due to	
Other Cerebral Arteriosclerosis Senescence (Include pregnancy within 3 months of death)	

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Carroll Gerhard M. D.
Address 2925 N. Charles St. Date Aug 30, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G20322

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6615 Park Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6615 Park Heights Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JEROME E. ULLMAN.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Frances O. Ullman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1898.

8. AGE: Years	Months	Days	If less than one day
45	8	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Executive:-Hochschild-
11. Industry or business Kohn & Co.

FATHER
12. Name Emanuel Ullman,
13. Birthplace Germany.

MOTHER
14. Maiden Name Minnie Hirshberg,
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Frances O. Ullman,
(b) Address 6615 Park Heights Ave.

17 (a) Cremation (b) Date thereof 8/31/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Harold Samuelson & Son
(b) Address 1902 Eutaw Place

19 (a) Huntington Williams, M.D.
(Date received by registrar) Registrar

AUG 29 1944
VS-M-14

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29th. 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1939, to Aug 29 1944, and that I last saw him alive on June 22 1944

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to	
Due to	
Other Conditions Hypertension	8 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan Bernstein M. D.
Address 1039 N. Calvert St Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G20323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20323

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave. & Lake Drive Riviera Apts.
(c) Hospital or institution: .....
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City ~~or town~~ Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Riviera Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME IDA RICE

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1876

8. AGE: Years 67 | Months 11 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Pa. (Town, county, and state)
10. Usual Occupation None
11. Industry or business .....

FATHER
12. Name Gustav Rice
13. Birthplace Germany.

MOTHER
14. Maiden Name Pauline Rhonheim,
15. Birthplace Germany.

16 (a) Informant Miss. Stella Rice,
(b) Address Riviera Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/44. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Chas. Sonnenblick & Son
(b) Address 1902 Eutaw Place.

19 AUG 29 1944 Date received by registrar Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28th. 1944, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26 1944 to 8/28 1944 and that I last saw h.e.r alive on 8/28 1944.

Immediate cause of death	Duration
1) Cerebral Hemorrhage	- 1 hr.
Due to -	
Due to Hypertensive Heart Disease.	5 yrs.
Other Conditions -	

(Include pregnancy within 3 months of death)
Date of operation - None
Major findings of operation: -
of autopsy: Dr.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? .....
(e) Means of injury .....
23. Signature Earl L. Chambers
Address 4108 Liberty Heights Ave. Date signed 8/29/44

G20324

G20324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Druid Park Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ivy T. Donaldson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Thomas H. Donaldson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1884

8. AGE: Years	Months	Days	If less than one day
59	8	4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Wiley
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Kate Misad
15. Birthplace Balto. Md.

16 (a) Informant Mrs. T. H. Donaldson
(b) Address 2316 Druid Park Drive

17 (a) Burial (b) Date thereof 8/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Lorraine
Location Balto. Md.

18 (a) Funeral director Carl Bradshaw & Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

AUG 29 1944

Form 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-27 1944, at 4:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1944, to 8-27 1944, and that I last saw h[illegible] alive on 8-27 1944.

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Diabetes mellitus	1 day
Due to Diabetes mellitus	4 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron J. Myron
Address Sinai Hospital Date signed 8-29-44

G20325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G20325

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out full words. Give exact street address or location. If not in a hospital or institution, write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
U. Hospital, Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Wicomico
(c) City or town Salisbury
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Perdue

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife Edith D. Perdue
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1892

8. AGE: Years	Months	Days	If less than one day: hr.	min.
52	1	2		

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Farmer & Poultry Man
11. Industry or business self

FATHER
12. Name Laurence W. Perdue
13. Birthplace Md

MOTHER
14. Maiden Name Martha Ellen Adkins
15. Birthplace Md

16 (a) Informant University Hospital
(b) Address Redwood at Greene

17 (a) Burial (b) Date thereof Aug 3, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkesburg M.E. Cemetery
Location Salisbury, Md.

18 (a) Funeral director Hall Hathaway & Co
(b) Address Salisbury, Maryland

AUG 30 1944 (b) Harrington for Williams, M.D.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1944, at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on 8/29 1944.

Immediate cause of death	Duration
Intestinal Obstruction & diffuse Peritonitis	3 days
Due to Amputated gall stones	Same
Due to	
Other Conditions Chronic Rheumatism	

(Include pregnancy within 3 months of death)
Date of operation 8/23/44
Major findings of operation: Peritonitis, Adhesions, Biliary Fistula
of autopsy: Unruptured Appendix, Diffuse Peritonitis, Ruptured Duodenal Ulcer

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Harris M. D.
Address University Hosp Date signed 8/30/44

G20326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 149B

G20326 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address —
(c) Hospital or institution: Union Mem. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 641 N. Kenwood Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Doris Marie Fillieux.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	W.	Married.

6 (b) Name of husband or wife Charles Allen Fillieux. 6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1915

8. AGE: Years	Months	Days	If less than one day
28	10	7	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation H. W.
11. Industry or business Home.

FATHER
12. Name Will Johnson.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Katherine Bethmann.
15. Birthplace Maryland.

16 (a) Informant Husband
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Rural
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-8 Arlington Ave
19 (a) AUG 30 1944 Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1944 at 7.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1944 to 8-28 1944 and that I last saw her alive on 8-28-1944

Immediate cause of death unexplained Shock following delivery. — Duration 2 hrs.
Due to —
Due to —
Other Conditions — post
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature A. Franklin McCauley M. D.
Address 3047 St. Paul St. Date signed 8-29-44

A. Franklin McCauley

AB-89151 G20327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G20327

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-1day
(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Washington Cheek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Pattie (D)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 25-1881
8. AGE: Years 63 | Months - | Days 1 | If less than one day hr. min.
9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alfred Cheek
13. Birthplace N.C.

MOTHER
14. Maiden Name Theaney Williams
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 8/30/1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Cedar Hill Rd
18 (a) Funeral director Mrs Kate R. Williams
(b) Address 312 N Schroeder St
19 (a) (b) Registrar
(Date rec'd by registrar) AUG 30 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26- 1944, at 7.10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-25- 1944 to 8-26- 1944, and that I last saw h. im alive on 8-26- 1944.

Immediate cause of death: Bronchopneumonia
Due to: Uremia

Duration
2 days
2 wks

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Pneumonia + Cystitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hauck L. Bolton M. D.
Address City Hosp. Date signed 8/29/44

G20328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93N

G20328 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2234 Edmonton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 Edmonton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gertrude Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Widowed

6 (b) Name of husband or wife Chas W. Thomas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1869

8. AGE: Years 75 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Jerry Riggs
13. Birthplace Md

MOTHER
14. Maiden Name Susan ?
15. Birthplace Md

16 (a) Informant Mary Brown
(b) Address 2232 Edmonton Ave

17 (a) Buried (b) Date thereof 8/30/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cemetery
Location West Ave Md

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 327 N Schroeder St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

AUG 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 27 1944 at 1 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944 to Aug 27 1944 and that I last saw alive on Aug 27 1944

Immediate cause of death	Duration
Cardio-Vascular disease	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H Watts M.D.

Address 5154 Edmonton Ave Date signed 8/29/44

G20329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940

G20329 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 906 Bennett Place
(c) Hospital or institution: D.O.A

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 906 Bennett Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME Jessica Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Ishmeal Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1900

8. AGE: Years	Months	Days	If less than one day
44	4	12	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Addie Johnson
13. Birthplace Va.

MOTHER 14. Maiden Name Emily Warren
15. Birthplace Md

16 (a) Informant Emily Warren Johnson
(b) Address 906 Bennett Place

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Aug. 31 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director Mrs. Katie L. Gilliam
(b) Address 3223 N. Schroeder St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/27 1944, at 2.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury

23. Signature Chester J. Jaleski M.D. Medical Examiner.
Date signed 8/27/44

G20330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94

Registered No. G20330

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3602 Third St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Third St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie E. Connor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Harry H.
6 (c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.) Oct 3-1881
8. AGE: Years 62 Months 9/10 Days 24 If less than one day hr. min.
9. Birthplace Kent Co., Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name John Taylor
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Martha
15. Birthplace Kent Co. Md.

16 (a) Informant Mrs Harry H Connor
(b) Address 3602 Third St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd A.A.Co.

18 (a) Funeral director Earl L. Keas
(b) Address Huntington Williams Md.

AUG 30 1944 (Date rec'd by registrar)

Registrar

V8 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27th 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to Aug 27 1944, and that I last saw ... alive on Aug 27 1944.

Immediate cause of death	Duration
Cerebral Thrombosis	3 Days
Due to Angina Pectoris	Indef.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. L. Campbell M. D.
Address 164 Hanover St. Date signed 8/29/44

G20331

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46d

AB-89460

Registered No. G20331

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 West Saratoga St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Henderson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Sam (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1876

8. AGE: Years	Months	Days	If less than one day
67	8	3	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Furgerson -(D)
13. Birthplace Virginia

MOTHER
14. Maiden Name Emma Webb (D)
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals-Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem
Location A. C. County Md
18 (a) Funeral director Williams & Jackson
(b) Address 916 Pimlico ave.

AUG 30 1944 (Date filed by Registrar)
(b) Huntington Williams, M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28- 1944, at 4.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-20-44 1944, to 8-28 1944, and that I last saw her alive on 8-28- 1944.

Immediate cause of death Carcinoma of rectum & metastases to liver.

Duration
3 ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard E. Dalton M.D.
Address Balt. City Hosp. Date signed 8/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20332
455474

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

109 ✓ Registered No. G20332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1437 Webb St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ned Shaw.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-3-17

8. AGE: Years	Months	Days	If less than one day
27 26	-	24	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Truck Driver
11. Industry or business

FATHER
12. Name Sam Shaw
13. Birthplace Va.

MOTHER
14. Maiden Name Ezra Brown
15. Birthplace Va

16 (a) Informant Recorder.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 8/30/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westminster, S. C.
Location

18 (a) Funeral director Lotts Bros'.
(b) Address 1408 Ashland Ave.

AUG 30 1944 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1944, at 4:42 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June. 7 1944, to Aug. 27 1944, and that I last saw him alive on Aug. 27 1944.

Immediate cause of death: Pneumococcal meningitis — Duration 2 months
Due to: Secondary to pneumonia — 2½ month
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Bennington M.D.
Address JHH Date signed 8/29

G20333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20333 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Payson
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Mansel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William R Mc Master

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4th 1905

8. AGE: Years 39 | Months 5 | Days 24 | If less than one day hr. min.

9. Birthplace N. B. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name H. W Mc Master
13. Birthplace N. B.

MOTHER
14. Maiden Name Ada Townsend
15. Birthplace N. B.

16 (a) Informant Katherine Mc-Master
(b) Address 2824 Mansel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 1-44 (month) (day) (year)
(c) Cemetery or crematory Woodbridge Cem
Location Washington Blvd.

18 (a) Funeral director John G Mosan
(b) Address 3000 E Baltimore St

19 (a) AUG 30 1944 (Date received) Huntington Williams, M.D.

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1944, at 10:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1944, to Aug 28 1944, and that I last saw h alive on Aug 28 1944.

Immediate cause of death: Undetermined — Duration

Due to

Due to

Other Conditions: Following appendectomy 8 hrs. (Include pregnancy within 3 months of death)

Date of operation 8-28-44

Major findings of operation: Acute appendicitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mark D. Baldwin M. D.

Address West Baltimore Gen. Hosp. Date signed 8-28-44

G20334

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 119a

G20334 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1427 Raleigh Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1427 Raleigh Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecilia J. Adams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 44

8. AGE: Years | Months: 7 | Days: 20 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William F. Adams
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Agnes Swanski
15. Birthplace Balto. Md.

16 (a) Informant Agnes Adams
(b) Address 1427 Raleigh Way

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 8/30/44 (month) (day) (year)
(c) Cemetery or crematory Sac. Heart of Mary
Location German Hill Rd.

18 (a) Funeral director Shepherd-Fitchett
(b) Address 1100 E. Raywood Ave.

19 (a) AUG 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1944, at 9 AM

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diarrhea, infantile

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 8-29-44

C 0335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83 W

G20335 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2536 Edmondson Avenue.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2536 Edmondson Avenue. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Henry Howard Bye

3 (b) If veteran, name war ---

3 (c) Social Security Account No. ---

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Clara M. B. Bye

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 25-1865

8. AGE: Years 78 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Chester County, Pennsylvania. (Town, county, and state)

10. Usual Occupation Veterinary Surgeon

11. Industry or business

FATHER
12. Name Frederick Randolph Bye
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Martha Purnell
15. Birthplace Elkton, Maryland.

16 (a) Informant Mr. H. Burton Bye
(b) Address 7 Paradise Ave-Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof August 31-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.,
(b) Address North & Penna Aves-Baltimore, Md.

19 (a) (Date received by Registrar) (b) Registrar

AUG 30 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29th 1944, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1932 19... to Aug 29 1944. and that I last saw him alive on Aug 28 1944.

	Duration
Immediate cause of death Cerebral Hemorrhage	3 days
Due to Arterio-sclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Homer L. Todd M.D.
Address 735 N Fulton Ave Date signed 8/29/44

20336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. B 20336.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 700 W. 40th St.

(c) Hospital or institution: Home for Incurables

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 700 W. 40th St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME Ellen Andrew Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1866

8. AGE: Years 78 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Harpers Ferry, W. Va. (Town, county, and state)

10. Usual Occupation Kept Boarding House

11. Industry or business

FATHER

12. Name Rev. Ezekiel Richardson

13. Birthplace Baltimore, Md

MOTHER

14. Maiden Name Margaret Poole

15. Birthplace Baltimore, Md

16 (a) Informant Home for Incurable Records

(b) Address 700 W. 40th St. - M.F.D.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md. Huntington Williams, M.D.

19 (a) AUG 30 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1944 at 4.04 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/18 1936 to 8/29 1944, and that I last saw he alive on 8/28 1944.

Immediate cause of death: Cerebral Vascular Accident — Duration 48 Hours

Due to Hypertensive Cardio-Vascular Renal Disease — 16 years

Due to Coronary Occlusion — 2 years

Other Conditions Cerebral Vascular Accident — 10 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature W. Grafton Thompson M. D.

Address 214 Medical Arts Bldg Date signed 8/29/44

VS 3

G20337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 27a

G20337 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2430 Ellamont St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 1
(d) Street No. 2430 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY LOUISE HAMPSHER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William A. Hampsher
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23rd 1874

8. AGE: Years	Months	Days	If less than one day
70	0	5	hr. min.

9. Birthplace Phoenix, Balto. Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name David Kirk
13. Birthplace Philadelphia, Pa.

MOTHER
14. Maiden Name Rosetta McDonough
15. Birthplace Md.

16 (a) Informant Mr. William A. Hampsher
(b) Address 2430 Ellamont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/31/44 (month) (day) (year)
(c) Cemetery or crematory Middletown, Md.
Location Frederick County

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Local Registrar) (b) Huntington Williamson M.D.

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28, 1944, at 1020 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1944, to Aug 28 1944, and that I last saw h[illegible] alive on 19

Immediate cause of death: Acute Cholecystitis — Duration 4 Days

Due to

Due to

Other Conditions: Bilateral Lower Extremity Edema and Paralysis since 1915 — 29 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Johnson
Address 403 Med Arts Bldg Date signed 8/29/44

G20338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 550

G20338 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 49 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 151 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William L. Horlacher Sr.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife Mary V. Dorsey
6 (c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) Feb 7, 1886

8. AGE: Years	Months	Days	If less than one day
58	5	19	hr. min.

9. Birthplace Baltimore Md (town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self

FATHER
12. Name Wm L. Horlacher
13. Birthplace Ga.

MOTHER
14. Maiden Name Helen V. Whitaker
15. Birthplace Md.

16 (a) Informant family (b) Address 151 Hanover St
17 (a) B- (Burial, cremation, or removal) (b) Date thereof 7-1-44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location E. Valley Highway
18 (a) Funeral director H. L. McKinney
(b) Address 120 E. Fort Ave.
19 (a) (Date received by registrar) 6-30-1944 (b) Huntington Whittemore, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1944 at 8 40 PM
21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Aug. 28 1944 and that I last saw h[illegible] alive on Aug. 28 1944.

Immediate cause of death	Duration
Carcinoma of thyroid with metastasis to mediastinum and lungs	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? at M (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Paul H. Lukats M.D.
Address 1213 Light Street Date signed 8/29/44

G20339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1860

G20339 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2403 Maryland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BENJAMIN F. HOUCK.

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-0584

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary Houck

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6 / 1 / 1884

8. AGE: Years 60 | Months 02 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Sheet Metal Worker

11. Industry or business E. A. Register

FATHER 12. Name Jesse A. Houck

13. Birthplace Md

MOTHER 14. Maiden Name Mary E. Hautsock

15. Birthplace Md

16 (a) Informant Mrs Stanley M. Baker

(b) Address 2403 Maryland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 30 44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore Md

18 (a) Funeral director J. F. Wilson & Son

(b) Address Eutaw Place & Lanvale

19 AUG 30 1944 (Date rec'd by registrar) (by) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 27 1944, at 2 30 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, Lobar

Due to Contusion of neck

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 12/6

(a) Date of injury 8-19-44 at 1 P M.

(b) Where did injury occur? above address

(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? no

(d) Means of injury stumbled & fell downstairs

(e) Signature T. Z. Wollenweber M.D. Medical Examiner.

Date signed Aug 27 44

VS 151

G20340

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46f

G20340 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2588 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 48yr's

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2588 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis J. Yockel

3 (b) If veteran, name war	3 (c) Social Security Account No. 214-01-8706

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5 1896

8. AGE: Years	Months	Days	If less than one day
48	7	23	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Bottler
11. Industry or business National Brew. Co.

FATHER
12. Name Alexander F. Yockel
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ella R. Humbert
15. Birthplace Carroll Co Md.

16 (a) Informant Henry J. Yockel
(b) Address 119 S. Wickham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn

18 (a) Funeral director Harry A. Arnavoch
(b) Address 4204 Ridgewood Ave

19 (a) (Date received by Registrar) AUG 30 1944 (Registrar)

Huntington Hamilton M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 30 1944 to Aug 28 1944, and that I last saw him alive on Aug 28 1944.

Immediate cause of death	Duration
Cardiac Asthma	3 da.
Due to Sarcoma Lung, Sarcoma intestines	3 mo
Due to Colon metastases	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl M. Koons M. D.
Address 806 N Fulton Ave Date signed Aug 29 1944

Earl M. Koons

G20341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 169

Registered No. G20341

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County.....
(c) City or town Sharon Hill (If outside city or town limits, write RURAL and give town)
(d) Street No. 73 Ithgle Street (If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Joseph M. Reed

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1895

8. AGE: Years	Months	Days	If less than one day
48 49	11	-	....hr. ....min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation Supervisor
11. Industry or business

FATHER
12. Name James Reed
13. Birthplace

MOTHER
14. Maiden Name Catherine Gilbert
15. Birthplace

16 (a) Informant.....
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 8/30/44 (month) (day) (year)
(c) Cemetery or crematory.....
Location Philadelphia, Pa.

18 (a) Funeral director Williams & Cook
(b) Address 1217 St Paul St

19 (a) AUG 30 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1944, at 1.0 5 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Crushed pelvis and left upper leg

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: Baldwin Locomotive Works
(a) Date of injury August 29 1944 2 P.M.
(b) Where did injury occur? Plant #1 Clinton ST
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Crushed between locomotives

23. Signature Robert L. Fraser M.D.
Medical Examiner.
Date signed August 30, 1944

G20342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163 H Registered No. G20342

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6028 Pinehurst Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) [illegible]

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give road)
(d) Street No. 6028 Pinehurst Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Bertha E. Wolfgang

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George M. Wolfgang

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24-1907

8. AGE: Years 37 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas R. Lowe
13. Birthplace Maryland

MOTHER
14. Maiden Name Isabelle Preston
15. Birthplace Maryland

16 (a) Informant George M. Wolfgang
(b) Address 6028 Pinehurst Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

AUG 30 1944 (Date rec'd by registrar) (b) Huntington Terrace, Md. Registrar

VS 181

MEDICAL CERTIFICATION A

20. DATE OF DEATH August 29 1944, at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to carbon monoxide

Due to

Other Conditions Mental dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury August 29, 1944 M. a.
(b) Where did injury occur? 6028 Pinehurst
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Turned on gas in b

23. Signature H. L. Wollen Wolfe M.D.
Medical Examiner M.D.
Date signed 8-29-44

G20343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G20343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Union Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Union Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Albert Misal

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Barbara May Misal
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 17-1866
8. AGE: Years 76 Months 5 Days 11 If less than one day hr. min.
9. Birthplace Carroll Co. Maryland (town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Retired 11 years
FATHER 12. Name Unknown
13. Birthplace Germany
MOTHER 14. Maiden Name Caroline —
15. Birthplace Germany
16 (a) Informant Harvey D. Misal
(b) Address 1008 Union Avenue
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 31-1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Baltimore Co. Md.
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
(Signature) Huntington Williams, M.D.

AUG 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28- 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1944 to Aug 28 1944, and that I last saw him alive on Aug 27 1944

Immediate cause of death Cerebral Hemorrhage. — Duration 10 days.
Due to Senile-vascular-hypertensive disease — 10 yrs
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operations:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 846 W 36th. Date signed 8/29/44

G20344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH #12

G20344 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 McElderry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2237 McElderry St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Neumeister

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-7190

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19-1886

8. AGE: Years	Months	Days	If less than one day
58	3 2	30 9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Northeastern Supply Co.

FATHER
12. Name Henry Neumeister
13. Birthplace Germany

MOTHER
14. Maiden Name Not Known
15. Birthplace Balto. Md.

16 (a) Informant Minnie Wortsek
(b) Address 2237 McElderry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location Gt Donnell St.

18 (a) Funeral director John F. Miller
(b) Address 2034 Jefferson St.

19 (a) (Date received) AUG 30 1944 Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 28 1944 at 8A M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to Aug 28 1944 and that I last saw him alive Aug. 25 1944.

Immediate cause of death	Duration
(a) Acute Cardiac Failure	few hours
Due to Cancer of the Lung	1 year
Due to with generalized metastases	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2432 Monument St Date signed 8/30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20345

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 929 Hurlock Court (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Eliza Billups
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. W
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/26/1882
8. AGE: Years 61 Months 8 Days 3 If less than one day .....hr. .....min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Thomas Billups
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Lawson
15. Birthplace Md.

16 (a) Informant Mamie Andro
(b) Address 1304 Mc Elderry St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug. 31 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location.....
18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Stanley Ave
19 (a) AUG 30 1944 (Date filed by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1944 at 10 30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury.....at.....M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? .....While at work?.....
(d) Means of injury.....

23. Signature H. L. Mackenzie M.D. Medical Examiner.
Date signed 8-30-44
Howard J. Andrews, M.D.

G20346

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944 G20346

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 N. Carrollton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William H. Lacey
3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elizabeth Lacey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-31-1895

8. AGE: Years	Months	Days	If less than one day
49	-	28	hr. min.

9. Birthplace Warrington, Va (town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name John Lacey
13. Birthplace Va

MOTHER
14. Maiden Name Helen Priest
15. Birthplace Va

16 (a) Informant Elizabeth Lacey
(b) Address 726 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Ebron O. Wilson
(b) Address 1000 Druid Hill Ave.

19 (a) AUG 30 1944 (Date rec'd by registrar) (b) Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1944 at 2:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Anesthesia - ether

Due to Fracture of femur

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2 P.M. Aug. 22, '44
(b) Where did injury occur? 3404 Clairmont Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? —
(d) Means of injury While changing a tire

23. Signature Peter H. Leibelman M.D.
Medical Examiner.
Date signed 8-30-44

G20347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G20347 Registered No.

RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 716 Homestead St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Homestead St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bud Y Carlton (or) Bud Burrell Carlton

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-3718

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 8 1890

8. AGE: Years	Months	Days	If less than one day
54	7	22	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Seaman
11. Industry or business

FATHER 12. Name Carey Carlton
13. Birthplace Virginia

MOTHER 14. Maiden Name ?
15. Birthplace Virginia

16 (a) Informant Julia K Dodd
(b) Address 716 Homestead St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd

18 (a) Funeral director Martin W. Kipp's Sons
(b) Address Howard & Ash Sts.

19 (a) AUG 30 1944 (Date received) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1944 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1944 to Aug 30 1944 and that I last saw h[illegible] alive on Aug 27 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 years

Due to —

Due to

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. J. Strickler M.D.
Address 632 Lanvale Date signed Aug 29/44

H. J. STRICKLER, M.D.

G20348 MAYS BALTIMORE CITY HEALTH DEPARTMENT G20348
CERTIFICATE OF DEATH 161C Registration No.

ALL RIGHTS RESERVED FOR BeMDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Dolan Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Clarancave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mays (Henry Lee Jr.)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 21st 22 '44
8. AGE: Years | Months | Days 7 hr | If less than one day min.
9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Henry Lee Mays
13. Birthplace Balto Md.
MOTHER 14. Maiden Name Margaret Stanley
15. Birthplace Brookeville Md.
16 (a) Informant Mother
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd
18 (a) Funeral director M. W. E. Dipple's Sons
(b) Address 7110 Belair Rd.
19 (a) (b) Huntington Wilkinson, M.D.

AUG 30 1944
VS 158

MEDICAL CERTIFICATION
20. DATE OF DEATH Aug 29 1944 at 10:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27 1944 to Aug 29 1944 and that I last saw h[illegible] alive on Aug 29 1944.
Immediate cause of death Stillborn
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 6 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. Lloyd Crawford M.D.
Address 5401 Belair Rd Date signed Aug 30 1944

G20349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43d

G20349 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3723 FOSTER AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 62 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3723 FOSTER AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH SCHEMMEL

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: REINHOLD SCHEMMEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): APR. 12 1858

8. AGE: Years: 86 | Months: 4 | Days: 17 | If less than one day: hr. min.

9. Birthplace: GERMANY
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: UNKNOWN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: ADAM GERLACH (SON IN LAW)
(b) Address: 3723 FOSTER AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 1/44 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: EASTERN AVE EXT.

18 (a) Funeral director: Lillyard Zeiler & C.
(b) Address: 403 S. WOLFE ST.

19 (a) AUG 30 1944 (Date received by Registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 29 1944 at 10/20 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1943 to Aug 29 1944 and that I last saw h alive on Aug 28 1944.

Immediate cause of death: Hypertensive arteriosclerotic C.V. Disease
Cerebral Hemorrhage — Duration: 7-15-43 / 8-28-44

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: E. A. Schemmel M. D.
842 N. Eutaw Date signed 8-29-44

G20350

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20350 X 119a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto.
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? —, (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Robar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 18 1943

8. AGE: Years	Months	Days	If less than one day
1	—	11	hr. min.

9. Birthplace Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Arthur C. Robar
13. Birthplace Canada

MOTHER
14. Maiden Name Helen E. Loughlan
15. Birthplace Pa.

16 (a) Informant Mrs. Helen E. Robar
(b) Address Reisterstown Rd. Owings Mills

17 (a) Burial (b) Date thereof 9/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Frank H. Nuerd
(b) Address Pikesville, Md.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar)

AUG 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1944, at 12 N.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1944 to 8-29 1944 and that I last saw her alive on 8-29 1944.

Immediate cause of death	Duration
a. Cardio-respiratory Failure	5 min.
Due to Toxemia + dehydration	3 da.
Due to Infectious Diarrhea	5 da.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Lange M. D.
Address Upton & Hayes. Date signed 8-29

G20351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30F

G20351 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 103 N Mount St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 103 N Mount St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Faulcon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Infant Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13, 1944

8. AGE: Years	Months	Days	If less than one day
		17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles James Faulcon
13. Birthplace Littleton N. C

MOTHER
14. Maiden Name Lucille Howard
15. Birthplace Wilmington N. C.

16 (a) Informant Charles J. Faulcon
(b) Address 103 N Mount St.

17 (a) Buried (b) Date thereof Aug 30, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (Date filed by registrar) 8-30-1944 (Signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29 1944, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1944, to 8-29 1944, and that I last saw h/m alive on 8-28 1944.

Immediate cause of death	Duration
Cardio-resp. failure	5 min
Due to Toxicity + Dehydration	3 da.
Due to Infectious Diarrhea	5 da.
Other Conditions Congenital Syphilis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature L. J. Lange M. D.
Address Mercy Hosp. Date signed 8-29

G20352

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 36

G20352 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 E. 26th St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 E 26th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Alan Bablan

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 8, 1927

8. AGE: Years	Months	Days	If less than one day
16	10	22	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business School Boy

FATHER
12. Name William Bablan
13. Birthplace Poland

MOTHER
14. Maiden Name Jane Cohen
15. Birthplace Baltimore Md

16 (a) Informant Mrs Jane Bablan
(b) Address 514 E 26th St

17 (a) Burial (b) Date thereof Aug. 31, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem.
Location E Baltimore St.

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) AUG 31 1944 Huntington Williams M.D.
(Date received by registrar) Registrar
(b)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 19 44, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Enquiry-Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Poliomyelitis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Charles J. Lubinski M.D.
Medical Examiner.
Date signed 8/30/1944

G20353

G20353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 58 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ellie Amy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Black

6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-20-30

8. AGE: Years 14 | Months 5 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Boyd Amy
13. Birthplace (Va)

MOTHER
14. Maiden Name Mary Amy Smith
15. Birthplace (Va)

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Carl H. Alexander
(b) Address 927 N. Mount St.

AUG 31 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-1944, at 1 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20-1944 to 8-29-1944 and that I last saw her alive on 8-29-1944

Immediate cause of death	Duration
cardiac failure	
Due to Rheumatic heart disease, mitral & A. Sand A.I.	
Due to A.I. and ? Tricuspid I.	
Other Conditions Subacute bacterial Endocarditis ? healed	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Abraham Cenecin M. D.
Address J. Hopkins Hospital Date signed 5-24

VS 160

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G20354 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 N. WASHINGTON ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 N. WASHINGTON ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME REBECCA KLAWANSKY

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife SAMUEL

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace RUSSIA
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name DAVID
13. Birthplace RUSSIA

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace RUSSIA

16 (a) Informant MRS. BOARSH
(b) Address 1313 N. WASH. ST

17 (a) BURIAL (b) Date thereof 8-31-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory ROSEDALE
Location Pkwy Rd + HAMILTON AVE

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto ST

19 (a) (Signature) Huntington Williams, M.D.
AUG 31 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-44 19 , at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1944 to 8/30 1944 and that I last saw h[illegible] alive on 8/30 1944

Immediate cause of death Acute Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Hamstead M.D.
Address 733 August St Date signed 8/31/44

JL - 89395 G20355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20355

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 524 W. Cross St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Goodwin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1883

8. AGE: Years	Months	Days	If less than one day
60	10	24	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER | 12. Name Richard
13. Birthplace Md.

MOTHER | 14. Maiden Name Sarah Johnson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address

17 (a) Burial (b) Date thereof 9/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Brewer Hill
Location Annapolis Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 AUG 31 1944 Huntington Williams, M.D. Registrar
(Date for day registered)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29 1944, at 7:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-14 1944 to 8-29 1944, and that I last saw him alive on 8-29 1944.

	Duration
Immediate cause of death: Cachexia	3 mo.
Due to: Carcinoma of Stomach	?
Due to:	
Other Conditions: Intercurrent pneumonia	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Carcinoma of Stomach
of autopsy: Ca Stomach + pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Hewlett E. Patton
Address Balt. City Hosp. Date signed 8/29/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20356

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH V 1440

G20356 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 2months

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Chase (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Virginia Bland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alexander

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) January 24, 1916

8. AGE: Years 28 | Months 7 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Levi Wilson
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Lelia Patterson
15. Birthplace: Virginia

16 (a) Informant: Hospital records
(b) Address: Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-31-44 (month) (day) (year)
(c) Cemetery or crematory: Glenwood Gdns
Location: Petersburg Va

18 (a) Funeral director: M A Franklin & J. Hemsley
(b) Address: 578 W. Biddle St

AUG 31 1944 (Date rec'd by Registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1944, at 8.23 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1944, to Aug. 28 1944, and that I last saw her alive on Aug. 28 1944.

Immediate cause of death: Uremia — Duration: 6 wks.

Due to: Malignant hypertension — Duration: ?

Due to:

Other Conditions: Pregnancy interrupted 8/2/44 (Include pregnancy within 3 months of death)

Date of operation: Aug. 2, 1944

Major findings of operation: Pregnancy, 18 weeks.

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Philip P. Stepture, Jr. M. D.
Address: Johns Hopkins Hospital Date signed 8-28-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20357

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days) 64yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 N. Fulton Av.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Alma E. Deems.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William Deems
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 12 - 1880

8. AGE: Years 64 | Months 5 | Days 17 | If less than one day — hr. ..... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Housewife

FATHER
12. Name Don't Know
13. Birthplace —

MOTHER
14. Maiden Name Don't Know
15. Birthplace —

16 (a) Informant Lavenna Deems
(b) Address 1420 N. Fulton Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. Pickrell & Son
(b) Address Balto., Md.

AUG 31 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1944, at 10.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 4 1944, to Aug 29 1944, and that I last saw h.er alive on Aug 28 1944.

Immediate cause of death	Duration
Chr. Myocarditis	1943
Due to Coronary Thrombosis	8/27/44
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lavenna Deems
Address 1663 W. North Ave. Date signed 8/29/44 D.

G20358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44 N

Registered No. G20358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 Avondale Ave 15
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William M. Rippard

3 (b) If veteran, name war: Present

3 (c) Social Security Account No. 579-09-4150

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/26/1912

8. AGE: Years 32 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace Balto. Maryland
(Town, county, and state)

10. Usual Occupation Veteran

11. Industry or business U. S. Army

FATHER
12. Name James Rippard
13. Birthplace Md. (Howard Co.)

MOTHER
14. Maiden Name Bordel (Mary Jordita)
15. Birthplace Md. (Balto.)

16 (a) Informant Mr. & Mrs. James Rippard
(b) Address 3325 Avondale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Baltimore National
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

AUG 31 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1944, 12-00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1944 to Aug. 30 1944, and that I last saw him alive on Aug. 30 1944.

Immediate cause of death: Resp. Failure — Duration:

Due to Hodgkin's Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward Palmerton M. D.
Address University Hospital Date signed 8-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

G20359 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3601 Southern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: DRUCILLA FRANCES JONES

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James Alexander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 25, 1870

8. AGE: Years 74 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Davis
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Hix
15. Birthplace Va.

16 (a) Informant Mr. William Jones
(b) Address 3601 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/1/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
AUG 31 1944
Registrar for William [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29, 1944, at 11:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944, to Aug 29 1944 and that I last saw h[illegible] alive on Aug 29 1944

Immediate cause of death: Cardiac & Respiratory Failure — Duration 5 days
Due to: Cerebral Hemorrhage — 6 days
Due to: Arterio Sclerosis & High Blood Pressure — 5 yrs
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ord J. Zimmerman, M.D.
Address [illegible] Date signed 9/1/44

G20360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20360 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution:
St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hours
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 307 Honey Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Edward Moricle (Moricle)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20. 1944

8. AGE: Years | Months | Days | If less than one day hr. min.
4 hours

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Charles Moricle

13. Birthplace

MOTHER 14. Maiden Name Dorothy -

15. Birthplace

16 (a) Informant St. Joseph's Hospital
(b) Address 1400 N. Caroline St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 21. 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Rock
(b) Address 5305 Harford Rd

19 (a) Huntington Williams, M.D.
(Signature of registrar)

AUG 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/28 1944, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1944 to 8/28 1944 and that I last saw him alive on 8/28 1944.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nelson Jaworski M.D.
Address Date signed 8/29/44

G20361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 36

G20361

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Woodland Road
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Parkville, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3132 Acton Rd
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Martha O'Brien

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 10 1889

8. AGE: Years 5 Months 5 4 Days 20 If less than one day hr. min.

9. Birthplace Parkville, Md.
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business —

FATHER
12. Name Walter O'Brien
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Rupard
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 3132 Acton Rd, Parkville, Md.

17 (a) Burial (b) Date thereof 8 31 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director L. J. Rock
(b) Address 5305 Harford Rd, Baltimore, Md

19 (a) AUG 31 1944
(Date received by registrar)
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30 1944, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1944, to Aug 30 1944 and that I last saw her alive on Aug 30 1944.

	Duration
Immediate cause of death Respiratory Failure	
Due to Bulbar Poliomyelitis	2 days
Due to	
Other Conditions Pharyngeal Paralysis	

(Include pregnancy within 3 months of death)

Date of operation Aug. 29 1944

Major findings of operation: Tracheotomy

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hosp. Date signed 8-30

G20362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830

Registered No. G20362

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 639 West Barre Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 639 West Barre Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jane Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1874

8. AGE: Years 70 | Months 5 | Days 17 | If less than one day hr. min.

9. Birthplace Westmoreland County Va
(Town, county, and state)

10. Usual Occupation House wife at home

11. Industry or business

FATHER
12. Name William Jackson
13. Birthplace Westmoreland County Va

MOTHER
14. Maiden Name Sarah Holmes
15. Birthplace Westmoreland County Va

16 (a) Informant Lottie Tucker
(b) Address 639 West Barre Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1. 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City Maryland

18 (a) Funeral director Joseph A. Lively
(b) Address 109 North Mount Street

19 (a) (Date filed by registrar) (b) AUG 31 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-28 1944, at 7 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1944 to 8-28 1944, and that I last saw h[illegible] alive on 8-28 1944

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis + Paralysis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben Rhett M. D.
Address 1326 Druid Hill Ave Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G20363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G20363 Registered No.

PLEASE WRITE PLAINLY, WITH UNPADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulton + Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Amberley Ave (If rural give location) 29
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Catherine Platt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late George H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-76

8. AGE: Years	Months	Days	If less than one day
68	3	24	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jacob H. Cassell
13. Birthplace Md.

MOTHER 14. Maiden Name Josephine Anderson
15. Birthplace Md.

16 (a) Informant Mr. George H. Platt
(b) Address 4700 Amberley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.1.44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location #3901 Frederick Rd.

18 (a) Funeral director Harry H. Wilson
(b) Address 4101 Edmondson Ave.

19 AUG 31 1944 Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 19XX, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/5 19XX to 8/29 19XX, and that I last saw [illegible] alive on 8/29 19XX.

Immediate cause of death: Carcinoma sigmoid colon — Duration

Due to

Due to

Other Conditions emaciation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: carcinoma sigmoid colon

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hurston M. D.
Address St Agnes Hosp. Date signed 8-29-44

G20364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

150 C

G20364 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 10
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11days
(e) Length of stay in Baltimore (yrs., mos., or days) 1years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1243 East Madison Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Beulah Neal

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) April 12, 1908

8. AGE: Years	Months	Days	If less than one day
36	4	17	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Elliott Franks
13. Birthplace North Carolina

MOTHER
14. Maiden Name Emma Harris
15. Birthplace North Carolina

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 8 31 44 (month) (day) (year)
(c) Cemetery or crematory New Bern N C
Location New Bern, N.C.

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St. Huntington Williams, M.D.

19 (a) AUG 31 1944 (b) Registrar

VS 150 For O.H.K. Wollenberg, by Howard A. Rusk, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1944, at 10.30AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1944, to Aug. 29 1944, and that I last saw her alive on Aug. 29 1944.

Immediate cause of death	Duration
Shock	
Due to ? Drug poisoning	
Due to Procaine Sensitivity ?	
Other Conditions Pregnancy, term, delivered Aug. 29, 1944 (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

Over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Nicholson J. Eastman M.D.
Address Johns Hopkins Hospital Date signed 8-29-44

G20365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20365 Registered No.

PLACE OF DEATH:
Baltimore City, Maryland
(a) Street address Broadway at Fairmount
(c) Hospital or institution:
Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) entire

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 617 No. Highland
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Barbara Dohmer (Barbara Dohmer)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8. 1876

8. AGE: Years 67 | Months 9 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Boarding house keeper

11. Industry or business

FATHER
12. Name Conrad Dohmer
13. Birthplace Md. (?)

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Joseph H. Spence
(b) Address 624 N. Robinson ST. Balto.

17 (a) Burial (b) Date thereof Sept. 1/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville, Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

AUG 31 1944 (b) Huntington Woods, Md.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-1944, at 5:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1944, to 8-29 1944, and that I last saw her alive on 8-29 1944.

Immediate cause of death: Coronary occlusion

Due to: Coronary sclerosis & Hypertension

Due to:

Other Conditions: Myocardial insufficiency

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dunlop Dey M. D.

Address Church Home & Hosp. Date signed 8-29-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20366 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sanai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6749 Graceland Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Karczeski — Walter Karczewski

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-4085

4. Sex: male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Dorothy Karczewski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11 1890

8. AGE: Years 53 | Months 9 | Days 18 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business Krail Packing Co

12. FATHER Name Andrew Karczewski

13. Birthplace Poland

14. MOTHER Maiden Name Antonina

15. Birthplace Poland

16 (a) Informant Mrs Agnes Karczewski

(b) Address 6749 Graceland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sep 2 / 44 (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M. Weber

(b) Address 400 E. Chester Street

19 (a) (Date received by registrar) AUG 31 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-29-44 1944, at 7:43 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1944, to 8-29 1944, I last saw him alive on 8-29 1944

Immediate cause of death	Duration
Cardiorespiratory failure	
Due to Myocardial insufficiency	?
Due to Coronary insufficiency	?
Other Conditions Hypertension - arteriosclerosis (Include pregnancy within 3 months of death)	3 yrs +

Date of operation

Major findings of operation:

of autopsy: Coronary arteriosclerosis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Byron J. Byers M. D.

Address Sinai Hospital Date signed 8-29-44

G20367

459063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 109 Registered No. G20367

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town West New York.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5906 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dewey Mathews

3 (b) If veteran, name war: World War I-II

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	married

6 (b) Name of husband or wife Hazel

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 7-21-98

8. AGE: Years	Months	Days	If less than one day
46	1	9	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Bank Clerk.

11. Industry or business

FATHER 12. Name Frank Mathews

13. Birthplace Md.

MOTHER 14. Maiden Name Molly Bowman

15. Birthplace Md.

16 (a) Informant Records.

(b) Address

17 (a) Burial, cremation, or removal (b) Date thereof 9/1/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Lawn

Location Jersey City, N.J.

18 (a) Funeral director Milton M. Lutz & Son

(b) Address 219 Central Ave

19 AUG 31 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug - 30 1944, at 7.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug - 12 1944, to Aug - 30 1944, and that I last saw h[illegible] alive on Aug - 30 1944.

Immediate cause of death: Bronchiectasis + abscess Respiratory + Cardiac Failure — Duration

Due to: Hematothorax, ? hemopericardium, ? pneumonia (Lt. side) —

Due to: Bronchiectasis (Lt. lung) + ? neoplasm —

Other Conditions: Pt. had thoracotomy, freeing adhesions, + ligation of Pulm. Art. Rt. Side
(Include pregnancy within 3 months of death)

Date of operation 8-29-44

Major findings of operation: Massive adhesions purulent discharge, ? neoplasm

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John R. Cunningham M. D.
JHH.

Address Date signed 8/30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

H-20368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50 ✓ Registered No. G20368

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 d + Calvert
(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Maryland (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apts. #517
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Marion L. Henderson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mr. Chas. E. Henderson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 22 June 1896

8. AGE: Years 47 | Months 11 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Mr. Louis Lankehl
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mrs. Florence Wood
15. Birthplace Virginia

16 (a) Informant Husband
(b) Address alone

17 (a) Burial (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm Bros. Inc.
(b) Address 1214 E. Baltimore St.

19 AUG 31 1944 Huntington Williams Mgr.
(Date rec'd by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 30 Aug 1944 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 30 Aug 1944 to 30 Aug 1944 and that I last saw h alive on 30 Aug 1944.

Immediate cause of death: Cardiovasc. failure — Duration
Due to: Metastatic Carcinoma of Breast, Right
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Stephen J Van Dell III M. D.
Address Union Memorial Hosp. Date signed 8-30-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G20369 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 W Lexington
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 30yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 W. Lexington
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn R. Ruppert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Wm. Ruppert

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1892

8. AGE: Years 52 | Months 5 | Days 15 | If less than one day — hr. — min.

9. Birthplace Towson, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Isaac Rotruck
13. Birthplace Hartford Co. Md.

MOTHER 14. Maiden Name Madre Boger
15. Birthplace Hartford Co. Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-3-44 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson Md

18 (a) Funeral director Jno Leo H. Holland
(b) Address 1631 Druid Hill Ave

19 AUG 31 1944 (Date received by Local Registrar) Huntington Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug-30 1944, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-27 1944 to Aug-30 1944 and that I last saw h alive on Aug-30 1944

Immediate cause of death Coronary Thrombosis — Duration 4 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. F. Pifer M.D.
Address 1536 W. Lanvale St. Date signed Aug-31 1944

G20370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G20370 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2218 N. Calvert Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) --
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2218 N. Calvert Street (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Martha A. Streett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: William H. Street

6 (c) If alive, give age ---years

7. Birth date of deceased (mo., day, yr.): April 24, 1857

8. AGE: Years 87 | Months 4 | Days 6 | If less than one day: -- hr. --- min.

9. Birthplace: Rocks, Harford Co., Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: -----

FATHER: 12. Name: Thomas Macatee
13. Birthplace: Harford County, Md.

MOTHER: 14. Maiden Name: Ruth Streett
15. Birthplace: Harford County, Md.

16 (a) Informant: Mrs. Ruth Parker
(b) Address: 2218 N. Calvert Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.

18 (a) Funeral director: H. W. Mears and Son
(b) Address: 805 N. Calvert Street

AUG 31 1944 (Date received by Registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1944 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28/44 to 8/30/44, and that I last saw her alive on 8/30 1944

Immediate cause of death	Duration
Respiratory failure	
Due to generalized arteriosclerosis	
Due to	
Other Conditions Diabetes mellitus	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: I. Shonfeld M.D.
Address: 6018 N. Marshall Date signed: 8/31/44 M. D.

G20371 BALTIMORE CITY HEALTH DEPARTMENT 946 G20371
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4416 O'Donnell St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4416 O'Donnell St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Crawford

(b) If veteran, name war: World War
3 (c) Social Security Account No. 216-03-0781

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Hilda Deane

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Febr 7, 1892

8. AGE: Years 52 | Months 6 | Days 3 | If less than one day: hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Buffer
11. Industry or business Retired

FATHER 12. Name Geo Crawford
13. Birthplace Balto Md

MOTHER 14. Maiden Name Mary Ehlert
15. Birthplace Balto Md.

16 (a) Informant Mrs Hilda Crawford
(b) Address 4416 O'Donnell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2 44 (month) (day) (year)
(c) Cemetery or crematory New National Cem
Location Frederick Ave

18 (a) Funeral director J Hegmann & Son
(b) Address 32 S Broadway

19 (a) Aug 31 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1944, at 4 50 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed August 30, 1944

G20372
489783

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

81N

G20372
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1609 E. Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Carolyn Sayers.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-8-43

8. AGE: Years | Months 10 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Cindy Sayers
13. Birthplace Va

MOTHER 14. Maiden Name Mayne Boyles
15. Birthplace W. Va

16 (a) Informant Friend.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 1 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sylvatus Va.
Location

18 (a) Funeral director L. Hessmann & Son
(b) Address 32 S. Broadway.

19 (a) (Date rec'd by registrar) (b) AUG 31 1944 Registrar Huntington Hessmann

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1944, at 8.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1944 to Aug. 30 1944, and that I last saw her alive on Aug. 30 1944.

Immediate cause of death: STAPHYLOCOCCUS MENINGITIS — Duration 8/28
Due to STAPHYLOCOCCUS SEPTICEMIA — Duration 8/14
Due to
Other Conditions ANEMIA
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frances E. M. Reed M.D. Address 201 N. Calvert Date signed 8/30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20373

JO #70930

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 7mos. 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Price Baker

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Separated
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1903

8. AGE: Years 40 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Kentucky (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

MOTHER / FATHER
12. Name Jack Baker
13. Birthplace Kentucky
14. Maiden Name ? ?
15. Birthplace Kentucky

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL AUG 31 1944

18 (a) Funeral director Commissioner of Health
(b) Address
AUG 31 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25, 1944 at 11:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/3 1942 to 8/25 1944. and that I last saw h[illegible] alive on 8/25 1944.

Immediate cause of death: Pulmonary Hemorrhage — Duration: minutes
Due to: Pulmonary Tuberculosis ?
Due to:
Other Conditions: Bronchial Asthma ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Haller M.D.
Address BCH Date signed 8/26/44

VS 150

2116

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20374

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G20374 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1206 Mosher st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Mosher st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rena Ferrell Ballard.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Edward
6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) 5-28-1902

8. AGE: Years 42 | Months 3 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Howard County Md (Town, county, and state)
10. Usual Occupation Beautician
11. Industry or business —

FATHER
12. Name Charles Ferrell.
13. Birthplace Md

MOTHER
14. Maiden Name Lottie Williams
15. Birthplace Md

16 (a) Informant Edward Ballard
(b) Address 1206 Mosher st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-44 (month) (day) (year)
(c) Cemetery or crematory Western Star Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave

19 (a) [illegible] (b) Huntington Williams, M.D.

AUG 31 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1944, at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 8/31 1944, and that I last saw h[illegible] alive on 8/30 1944

Immediate cause of death Chronic Myocarditis

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David D. Runnells M. D.
Address 1111 Eutaw Pl Date signed 8/31/44

G20375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G20375 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BLANKS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Timonium
(If outside city or town limits, write RURAL and give town)
(d) Street No. Potspring Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. William Price WILLIAM ALEXANDER PRICE

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. NONE

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1865

8. AGE: Years	Months	Days	If less than one day
79	2	17	hr. min.

9. Birthplace Timonium, Balto. Co., Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Farm

FATHER
12. Name William Price
13. Birthplace Baltimore City, Md.

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Balto. Co., Md.

16 (a) Informant Miss Mary P. Bosley (Niece)
(b) Address 325 Hawthorne Rd., Rol.Pk.,City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1-44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson, Balto. Co., Md.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 106 W. North Av. (W.F.Wooden-Suc.

19 (a) [illegible] (b) [illegible]

AUG 31 1944

Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/29/44, 1944, at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19/ 1944 to 8/29/ 1944 and that I last saw him alive on 8/29/ 1944.

Immediate cause of death: Bronchopneumonia

Due to: Coronic Vasc. Lesions

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration
10 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Worthington, Jr.

Address Baltimore, Md. Date signed 9/1/44

G20376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G20376 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1123 N. Eutaw St
(c) Hospital or institution: Cecil Apts (Home)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 N. Eutaw St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Adelaide Arens Morawetz

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Albert R. Morawetz
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.): April 22 1858
8. AGE: Years 86 | Months 4 | Days 2 | If less than one day: hr. min.
9. Birthplace: Baltimore (Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none
12. Name of Father: Henry Arens
13. Birthplace: Germany
14. Maiden Name of Mother: Emma Simon
15. Birthplace: Baltimore Md
16 (a) Informant: Miss R. Elizabeth Arens (cousin)
(b) Address: 1123 N Eutaw St
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof: Sept-1-44 (month) (day) (year)
(c) Cemetery or crematory: Gwynn Mount
Location: Baltimore
18 (a) Funeral director: Stewart Mourning Co.,
(b) Address: 108 W. North Ave,
19 (a) AUG 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 19 44 at 8:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1936 to Aug 30 1944 and that I last saw him alive on Aug 28 19 44

Immediate cause of death	Duration
Arteriosclerosis, general, cerebral and Coronal	
Due to Senility	2 years
Due to Chronic nephritis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Paul H. McCullough
Address 24 E. Eager St Date signed 8/31/44 D.

G20377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G20377 Registered No.

Every item of information should be carefully supplied. Please write plainly, with unfading ink. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3610 Pams Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harriett C. Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/8/42

8. AGE: Years 1 | Months 9 | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Thomas Parks Jr

13. Birthplace Maryland

MOTHER 14. Maiden Name Esther St Rey

15. Birthplace Md

16 (a) Informant Emma St Parks

(b) Address 3610 Pams St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1 44 (month) (day) (year)

(c) Cemetery or crematory St Marys

Location Harpers

18 (a) Funeral director Ellsworth & Dorsey

(b) Address 3615 Chestnut Ave

19 (Date rec'd by registrar) AUG 31 1944 Huntington Williams, M.D.

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 1944, at 1.20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia due to 2nd & 3rd degree burns

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury August 25 1944 7 PM

(b) Where did injury occur? 3610 Pams ST

(c) Did injury occur at home, on farm, industrial place, in public place? at home While at work? no

(d) Means of injury Scalded by hot water

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed August 30, 1944

G20378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20378
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 S. Oldham St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 705 S. Oldham St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NETTIE BOLTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Benjamin T. Bolton
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) March 19, 1897

8. AGE: Years	Months	Days	If less than one day
47	5	11	hr. min.

9. Birthplace Louisville, Ky.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Joseph B. Watts.
13. Birthplace Kentucky

MOTHER
14. Maiden Name Ida Marsh
15. Birthplace Kentucky

16 (a) Informant Benjamin T. Bolton
(b) Address 705 S. Oldham St.,

17 (a) Burial (b) Date thereof Sept 2, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Colgate, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St Williams, Md

19 (a) (b)
Filed 1944 rec'd by registrar Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1944, at 12:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1 19 44 to Aug 30 1944 and that I last saw her alive on Aug 29 1944

Immediate cause of death Cerebral hemorrhage — Duration
Due to Malignant hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jack J. Senger, M. D.
Address 506 E Hoffman Ave Date signed 8/30/44

G20379

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20379

1 PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Whitaford
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joanna Wagner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months 2 | Days | If less than one day hr. min.

9. Birthplace Bel Air Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Paul Wagner
13. Birthplace North Caroling

MOTHER 14. Maiden Name Pauline Halloway
15. Birthplace North Caroling

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 2 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Dublin Cem
Location Harford Co. Md

18 (a) Funeral director H. B. Bayley
(b) Address Darlington Md.

(c) Filed SEP 1 1944 Registrar Huntington Williams, M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1944, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 8-31-1944, and that I last saw her alive on 8-31-1944.

Immediate cause of death	Duration
Sinus Thrombosis	1 day
Due to dehydration	1 week
Due to diarrhea	2 weeks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard John Koenig M. D.
Address Johns Hopkins Hosp. Date signed 8-31-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20380 LINK ✓ G20380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver sts
(c) Hospital or institution: St. Joseph's Hosp. 6-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 201 N. Streeper st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Link (Louis N. Link)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-8409

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lena Link

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 3 - 1883

8. AGE: Years	Months	Days	If less than one day
60	8	27	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Newspaper

11. Industry or business Proprietor

FATHER 12. Name Geo. Link

13. Birthplace ?

MOTHER 14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Mrs. Lena Link

(b) Address 201 N. Streeper st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 2 44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Baltimore

18 (a) Funeral director Philip Herwig Sons

(b) Address 2024 Orleans st

19 (a) Date received by Registrar SEP 1 - 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1944, at 6 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1944 to 8/30 1944, and that I last saw her alive on 8/30 1944

Immediate cause of death	Duration
Bilateral Lobar Pneumonia	
Due to	
Due to	
Other Conditions Arteriosclerosis Hypertrophy Prostatic Carcinoma (Include pregnancy within 3 months of death)	

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Wilson Lapsley M.D.
Address St Joseph Hospital Date signed 8/30 1944

G20381

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 a

Reg. Dist. No.

G20381

1. PLACE OF DEATH: Balto City
Borough
City or town: Balto
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 2349 Mast. Blvd
Stay in hospital or inst. (yrs., or mos., or days) 25 & 3
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town: Balto Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2349 Mast Blvd
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Margaret Shubbard (SHUBBURD)
3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feby 17 1887

8. AGE: Years 77 | Months 6 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Balto Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: John Fowler
13. Birthplace: Germany

MOTHER
14. Maiden name: Louise Maighard
15. Birthplace: Md

16. Informant: Family
Address: 2219 Wash Blvd

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) Sept 1 (day) -47 (year)
Cemetery or crematory: Loudon Park
Location

18. Funeral director: Edward Fowler
Address: 2359 Wash Blvd

19. SEP 1 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 19 44 at 6-30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from — 19 43 to Aug 29 19 44
and that I last saw h— alive on Aug 29 19 44

Immediate cause of death	DURATION
Acute Cardiac failure	
Due to Pneumonia	3 wks
Due to Cardiovascular Renal Cancer	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Dr. McKeiffer
M.D. or other
Address: 2470 Mast. Blvd Date signed Aug 31 -44

please write the causes of death clearly and legibly. Physicians: please
correct age is especially important.

G20382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. G20382 20382

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3617 Springdale Ave
(c) Hospital or institution:

15-8

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 Springdale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Sachs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Late Isaac
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1859
8. AGE: Years 85 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Abraham Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name Ida Luhn
15. Birthplace Russia

16 (a) Informant Phillip Sachs
(b) Address 3617 Springdale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 Sept 1 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 6.55

20. DATE OF DEATH August 31 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1944, to Aug 31 1944 and that I last saw h[e]d alive on Aug 31 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 5 days
Due to Arteriosclerosis - cerebral
Due to Arteriosclerosis - generalized
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Place Date signed Sept 1/44

G20383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓G20383 Registered No. 107

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4000 Eaton avenue
(c) Hospital or institution: Joachim's Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3014 Wayne avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Rev.) John M. Baker ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1862

8. AGE: Years	Months	Days	If less than one day
82	7	20	hr. min.

9. Birthplace Maryland (town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Nelson Baker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ann P. Atherton
15. Birthplace Virginia

16 (a) Informant Joachim Memorial
(b) Address 4000 Eaton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Greenmount Ave

18 (a) Funeral director Earl R. Hess
(b) Address 715 Light St.

19 (Date received by City Registrar) SEP 1 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION ✓

20. DATE OF DEATH 8/30 1944 at 9:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944, to 8/30 1944 and that I last saw him alive on 8/30 1944.

Immediate cause of death: Heart failure
Due to: Bronchopneumonia
Due to: Hypostatic congestion chronic valvular & old age
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Byron M. D.
Address St. Agnes Hosp. Date signed 8/30/44

G20384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

G20384

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1907 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 W. North Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NORA H. MOORE

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William Wesley Moore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18, 1869

8. AGE: Years 75 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Cambridge, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John T. Jackson
13. Birthplace Cambridge, Md.

MOTHER
14. Maiden Name Sarah Raleigh
15. Birthplace Cambridge, Md.

16 (a) Informant Mr. William W. Moore
(b) Address 1907 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory
Location Cambridge, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 1 - 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased during the period from 19 to 19; and that I last saw h[illegible] alive on Aug 30 1944

Immediate cause of death

Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 1923 N. Mont St. Date signed Sept 1 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G20385 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1756 Montpelier St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1756 Montpelier St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY BARBARA LORENZ

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 220-14-1685

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 11, 1885

8. AGE: Years 59 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Motion Picture Business

FATHER
12. Name John A. Lorenz
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Anna Gunther
15. Birthplace Germany

16 (a) Informant Mrs. E. Faber
(b) Address 1756 Montpelier St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 1 - 1944 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Aug. 31, 1944, at 10:40M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6, 1944, to Aug. 31, 1944. and that I last saw her alive on Aug. 30, 1944

Immediate cause of death: Carcinoma of the Colon — Duration: 1 yr.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Smith Singewald, M.D.

Address 1613 E. North Ave. Date signed 9-1-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20386 ✓ G20386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 110 N. Calhoun St
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2305 Brookfield Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Bondy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of ~~husband~~ wife Louise Bondy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ~~9-1-44~~ 3-14-62

8. AGE: Years 82 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Bohemia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Joseph Bondy
13. Birthplace Prague

MOTHER 14. Maiden name Marie Fiser
15. Birthplace Prague

16 (a) Informant Mrs. E. W. Bondy
(b) Address 2453 Eutaw Place

17 (a) Cremation (b) Date thereof 9/11/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Edward Sonneborn & Sons
(b) Address 202 Eutaw Place

19 (a) Sept 1944 (b) (Date rec'd by registrar) Huntington Williams, Registrar

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/ 1/ 19 44, to Sept 1 1944, and that I last saw h. alive on Sept 1 1944

Immediate cause of death	Duration
(a) Uremia	
Due to (b) Prostatic Hypertrophy	
Due to (c)	
Other Conditions Cerebral Thrombosis	

(Include pregnancy within 3 months of death)

Date of operation 8-6-44

Major findings of operation: Carcinoma Prostate

of autopsy: Uremia, Thrombosis Cerebral Vessels

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 2453 Eutaw Pl Date signed 9/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G20387

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5306 Candelia Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5306 Candelia Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby William Yacovissi
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 15, 1944
8. AGE: Years | Months 2 | Days 16 | If less than one day hr. min.
9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Samuel J. Yacovissi
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Agnes Ruth Clements
15. Birthplace Johnstown, Md.

16 (a) Informant Samuel J. Yacovissi
(b) Address 5306 Candelia Ave
17 (a) Burial (b) Date thereof 9-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Charles
Location Pikesville Md.
18 (a) Funeral director Joseph Bozza
(b) Address 5605 Belair Rd
19 SEP 1 - 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1944 at 12:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1944 to Aug 31 1944 and that I last saw h. alive on Aug 30 1944.

Immediate cause of death: Paton foramen ovale — Duration: since birth
Due to
Due to
Other Conditions Paton foramen ovale — since birth
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harris Hubbard M. D.
Address 2220 Garrison Blvd
Aug 31/44

G20388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

✓ G20388 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4½ days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 530 Lawrence Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years 8 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name John C. Taylor
13. Birthplace Meredithville Va.

MOTHER
14. Maiden Name Amanda Johnson
15. Birthplace Balto. Md.

16 (a) Informant Mrs Amanda Taylor
(b) Address 530 Lawrence st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Wm. J. Chatman Jr
(b) Address 600 Pricedale.

19 (a) Date received SEP 1 1944 (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1944, at 6.30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gun shot of wound involving skull cause

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-26-44 at 6.30 P M.
(b) Where did injury occur Lawrence - Sitting St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fire-arm - revolver

23. Signature Howard J. Chaillis M.D.
Medical Examiner.
Date signed 8-31-44

(over)

G20389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G20389

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3110 Westfield Ave #14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kunzelmann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 21. 1875

8. AGE: Years	Months	Days	If less than one day
69	3	-	hr. min.

9. Birthplace Austria-Hungary
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Peter Kunzelmann
13. Birthplace Austria-Hungary

MOTHER
14. Maiden Name Barbara ?
15. Birthplace Austria Hungary

16 (a) Informant Mrs Rose Kunzelmann
(b) Address 3110 Westfield Ave

17 (a) Burial (b) Date thereof 9-7-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Ruck
(b) Address 5306 Harford Rd

SEP 1 - 1944 (b) Huntington-Williams, Mgr.
(Date rec'd by registrar) Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1944 at 7 a.m. p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1944 to 8-31 1944, and that I last saw him alive on 8-31 1944.

Immediate cause of death Intra cranial injury — Duration 3 days

Due to Multiple fractures of skull

Due to Simple fall

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-29-44

Major findings of operation: Subarachnoid hemorrhage

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following.
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 8-28-44 at 7 a.m. p.m.
(c) Where did injury occur? Home Baltimore Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? no
(Specify type of place)
(e) Means of injury Simple fall

23. Signature J. W. Traynor M. D.
Address Md. Gen'l. Hosp. Date signed 8/31/44

Approved by Howard J. Madden, M.D.

G20390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G20390
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 N. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Millard McGrath

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Catherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26th 1884

8. AGE: Years	Months	Days	If less than one day
60	2	5	hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation Painter

11. Industry or business Self

FATHER
12. Name Joseph McGrath
13. Birthplace Ohio

MOTHER
14. Maiden Name Mary E. (Unknown)
15. Birthplace "

16 (a) Informant Catherine McGrath
(b) Address 2711 W. North Ave

17 (a) Burial (b) Date thereof 9/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md

18 (a) Funeral director Wilson Corkran
(b) Address 1217 Park Ave

19 (a) (b)

SEP 1 1944

Huntington Williams M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31- 1944, at 10:00 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractured ribs + pelvis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 8-31-44 at A M.
(b) Where did injury occur? 1706 N. Balto. St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Fell from a scaffold

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 8-31-44

G20391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1710

G20391

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-11
(c) Hospital or institution: Union Memorials Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. tract of land 1/2 Mile W. of Liberty Hgts. Near Waterworks Property Line
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Shaffer (Henry Schultz Schaeffer)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife Matilda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2nd - 1876

8. AGE: Years	Months	Days	If less than one day
70	2	26	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business At Large

FATHER
12. Name (Unknown) Schaeffer
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Harry Schaeffer
(b) Address Mt. Pleasant Beech Pocomoke City

17 (a) Burial (b) Date thereof 9-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Marks
Location Hampden Balto Md

18 (a) Funeral director Wilson Conkey Co
(b) Address 1214 E. Fort Ave

19 (a) SEP 1 - 1944
(Date rec'd by registrar) Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 28 1944 at 7 30 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon (Autopsy / Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 7 P.M. - 8-28-44
(b) Where did injury occur? Druid Park Drive & Liberty Heights
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by streetcar

23. Signature H Z Wollenweber M.D.
Medical Examiner.
Date signed 8-29-44

G20392 ✓ G20392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44B

Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1744 Homestead st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1744 Homestead St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Frederick Schmidt

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-0587

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 13 1919

8. AGE: Years	Months	Days	If less than one day
24	9	19	17 hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Book Keeper

11. Industry or business Commercial Credit Co.

FATHER
12. Name Christian F. Schmidt
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma E. Matthai
15. Birthplace Balto. Md.

16 (a) Informant Christian F. Schmidt
(b) Address 1744 Homestead St

17 (a) Burial (b) Date thereof 9/2/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Morland Park
Location Parkville, Md.

SEP 1 1944

(a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1944, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1942 to Aug 30 1944, and that I last saw him alive on Aug 30 1944

Immediate cause of death	Duration
Hodgkin's Disease	2 yrs
Due to	
Due to	
Other Conditions Cachexia, Respiratory Failure (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Vincent M. Messina M. D.

Address 14035 Charles St Date signed 8/30/44

G20393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. G20393

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1009 Pembridge Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2454 Oakley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Schultz
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Jennie Gertrude
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1891
8. AGE: Years 53 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House painter
11. Industry or business

FATHER: 12. Name Abraham
13. Birthplace Russia
MOTHER: 14. Maiden Name Shipra
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-1-44 (month) (day) (year)
(c) Cemetery or crematory Location New York City

18 (a) Funeral director Jack Lewis Inc.
(b) Address 1437 E. Balto St
Registered by registrar 1944 (Signature of funeral director or person acting as such)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31 1944 at 9:53 M

21. I certify that death occurred on the date above stated; that I attended deceased from dead on arrival 19 to Aug 31 1944 and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis — Duration Instantaneous

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. L. DeBartieri M. D.
Address 4723 Park Heights Ave Date signed Aug 31 1944

Coroner's Case No. 44 Allegheny Co. M.D. and Medical Examiner

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92

G20394
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 N. Bethel St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elijah Johnson

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 212-12-6997

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Elijah Johnson
13. Birthplace: Balto, Md.

MOTHER
14. Maiden Name: Laura Anderson
15. Birthplace: Balto. Md.

16 (a) Informant: Herbert Johnson (Brother)
(b) Address: 1423 6. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-2-44 (month) (day) (year)
(c) Cemetery or crematory: Balto. Nat'l. Cem
Location

18 (a) Funeral director: Joseph B. Locke, Jr.
(b) Address: 1304 N. Central Ave

19 SEP 1 - 1944 (Date rec'd by Registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30- 1944, at 1:45 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Chronic Valvular Disease

Due to

Other Conditions: Hypertrophy + dilatation of heart
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Mullen M.D.
Medical Examiner.
Date signed 8-31-44

B. 20395. ✓ X B 20395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mo
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md (b) County Catonsville
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 38 A Winters ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME John Ireland

3 (b) If veteran, name war: 7
3 (c) Social Security Account No.: 7

4. Sex: M | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alverta Ireland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887 1877

8. AGE: Years 57 | Months ? | Days ? | If less than one day ... hr. ... min.

9. Birthplace Howard Co. Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name Henry Ireland
13. Birthplace Md

MOTHER — 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant wife
(b) Address 38 A Winters Ave; Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-44 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Chapel
Location Baltimore Md

18 (a) Funeral director J E Pennybacker
(b) Address Ellicott City Md

19 (a) (Date rec'd by registrar) SEP 7 - 1944 (b) Huntington Williams, M.D.

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1944, at 2:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 3 1944 to Sept 6, 1944 and that I last saw h alive on 9/6 1944.

Immediate cause of death: Pneumonia — Duration: 7
Due to: Gangrene
Due to: Senility & arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: no
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
(f) Signature Marion E. Wilson
Address 803 Fremont Ave Date signed 9/6/44 (M/D)

C20396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C20396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2910 Montebello Terrace
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2910 Montebello Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr Chester P. Woodward

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nora V.

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Jan. 16 1878

8. AGE: Years 66 | Months S.T. 7 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Physician

11. Industry or business

FATHER
12. Name George Woodward
13. Birthplace

MOTHER
14. Maiden Name Ursula
15. Birthplace

16 (a) Informant Mrs. Nora V. Woodward
(b) Address 2910 Montebello Terrace

17 (a) BURIAL (b) Date thereof 9-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director L.T. RUCK
(b) Address 5305 Harford Rd.

19 (a) SEP 1 - 1944 Huntington Williams, M.D.
(Date received for registration) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1st 1944, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratcher M.D.
Medical Examiner.
Date signed Sept. 1st 1944

G20397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G20397 Registered No.

AB-89450

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2548 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 24-1865

8. AGE: Years	Months	Days	If less than one day
78	11	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Jeweler
11. Industry or business

FATHER
12. Name August Becker (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Johanna ?
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals-Record
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2-44 (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Fred Ave. Balto

18 (a) Funeral director John R. Kenny
(b) Address 1243 Leads Ln. Catonsville, Md

SEP 1 1944 (Date registered) (b) Huntington Williams, MD Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1944 at 7.05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-19 1944 to 8-29 1944 and that I last saw h im alive on 8-29-44 1944.

Immediate cause of death Uremia, Renal — Duration: ?

Due to Benign hypertrophy of prostate

Due to

Other Conditions Cardiac Failure — Duration: ?

(Include pregnancy within 3 months of death)

Date of operation August 29, 44

Major findings of operation: Benign hypertrophy of Prostate Uremia

Date of autopsy? on Investigation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury

23. Signature S. P. Hasara
Address Balto City Hosp Date signed 8-30-44 (M. D.)

G20398

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20398

CERTIFICATE OF DEATH 1242

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 W Caroline St
(c) Hospital or institution: St. Joseph's Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto Co.
(c) City or town Glendale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6759 Heatherbird Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie R Campbell.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles J. Campbell
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Sept 29th 1899

8. AGE: Years	Months	Days	If less than one day
44	11	1	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name John Weir
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr Charles J. Campbell
(b) Address 6759 Heatherbird Ave

17 (a) Burial (b) Date thereof Sept 1 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn Cem.
Location Eastern Ave

18 (a) Funeral director Earl L. Hess
Address 715 Light St.

SEP 1 - 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1944 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1944 to 8/30 1944, and that I last saw h[illegible] alive on 8/30 1944.

Immediate cause of death Cerebral Hemorrhage
Bleeding — Duration
Due to Contusion of Liver
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Melvin J. Jaworski
Address St Joseph Hospt Date signed 9/30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20399 BALTIMORE CITY HEALTH DEPARTMENT G20399
CERTIFICATE OF DEATH 97
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway - Fairmount
(c) Hospital or institution:
Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 17 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Perryman
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John B Numbers

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Georgiana Numbers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept - 7 - 1861

8. AGE: Years	Months	Days	If less than one day
82	11	24	hr. min.

9. Birthplace Perryman, Harford Co. Md.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name James Numbers
13. Birthplace ?

MOTHER
14. Maiden Name Sarah Ann Taylor
15. Birthplace Perryman

16 (a) Informant Church Home + Infirmary
(b) Address Broadway + Hospital

17 (a) Burial (b) Date thereof Sept. 3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Spesutia Luth.
Location Harford Co.

18 (a) Funeral director Jos. Jessing + Son
(b) Address Aberdeen, Md.

19 (a) SEP 2 1944 (b)
SEP 1 - 1944 Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1944 at 11:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16-1944 to 9-1-1944 and that I last saw him alive on 9-1-1944.

	Duration
Immediate cause of death Toxicity	24 hrs.
Due to Arteriosclerotic gangrene of rt. foot	26 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Generalized arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harrison Latta M. D.
Address Church Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.
MARGIN RESERVED FOR BINDING

G20400

St Agnes -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G20400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2521 Woodbrook Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2521 Woodbrook Lane (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Lena Weik

3 (b) If veteran, name war
3 (c) Social Security Account No. none
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Wilbur L.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr 6. 1874
8. AGE: Years 70 Months 4 Days 25 If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and State)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name John Clement
13. Birthplace Germany
14. Maiden name Rosina Ambrum
15. Birthplace Germany

16 (a) Informant Gertrude E. Weik
(b) Address 2521 Woodbrook Lane
17 (a) Burial (b) Date thereof 9-2-44 (burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md
18 (a) Funeral director Wilbur Coffee
(b) Address 1214 E Lond St
SEP 2 - 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1944, at 4:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1-44 to Sept 1-44, and that I last saw him alive on Sept 1-44
Immediate cause of death Uremia Poisoning
Contributory
Due to Chronic Interstitial nephritis

Duration
3 days
6 mos.

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Henry C Hewett M. D.
Address 1423 Mt Vernon Place Date signed Sept. 2/44

VS 150

G20401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G20401

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1040 Aisquith Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1944

8. AGE: Years	Months	Days	If less than one day
			hr. 55 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Williams
13. Birthplace South Carolina

MOTHER
14. Maiden Name Eva King
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 2 1944 Hunter Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1944, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 26 1944, to July 26 1944, and that I last saw him alive on July 26 19 44

Immediate cause of death Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stepter, Jr. M. D.
Address Johns Hopkins Hospi Date signed 8-1-44

12119

G20402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20402

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1755 Orleans Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Coles

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 24, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Sylvester Lawson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Helen Walker
15. Birthplace Virginia

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 2 1944 (Date rec'd by registrar) (Signature) Hunter H. Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26 1944, at 12:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 24 1944, to August 26 1944, and that I last saw h... alive on Aug. 26 1944.

Immediate cause of death	Duration
Prematurity	
Due to Maternal: Premature separation of placenta	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Philip P. Stapleton, Jr. M. D.
Address Johns Hopkins Hospital Date signed 8-28-44

VS 150

2120

G20403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20403
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 3-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2hrs. 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs. 20 min.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Stiles Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Pizza

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 23, 1944

8. AGE: Years | Months | Days | If less than one day: 2 hr. 20 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Paul Pizza
15. Birthplace Maryland

MOTHER 14. Maiden Name Lucille Hicks
15. Birthplace Kentucky

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 2 1944 (Date rec'd by registrar) Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1944 at 11:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23 1944, to Aug. 23 1944 and that I last saw him alive on Aug. 23 1944

Immediate cause of death Prematurity — Duration

Due to Maternal: Premature separation of placenta

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Stapleton, Jr. M. D.
Address Johns Hopkins Hospital Date signed 8-28-44

2118

Holmes

G20404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G20404 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 N. Mulberry
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Palmer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Taft Holmes
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) July 15, 1915

8. AGE: Years	Months	Days	If less than one day
29	1	16	hr. min.

9. Birthplace Mt. Gilead N. Carolina
(town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Charles Thompson
13. Birthplace Sandy Cy N. Carolina

MOTHER
14. Maiden Name Nora Moore
15. Birthplace Lockhart N.C.

16 (a) Informant Taft Holmes
(b) Address 1204 N. Mulberry

17 (a) Burial (b) Date thereof Sept 2 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wmston-Salem N.C.
Location Winston Salem N.C.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (b) Huntington Williams, M.D.
(Date rec'd by Registrar)
SEP 2 - 1944
VS 4

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1 1944, at 4 05 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1944, to 9-1- 1944, and that I last saw her alive on 9-1- 1944.

Immediate cause of death	Duration
Resp. & Cardiac failure	
Due to Uremia	
Due to Renal disease	
Due to Eclampsia	11 days
	over
Other Conditions Pregnancy 36 wks. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations:
of autopsy: No definite gross pathology

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Thomason M. D.
Address Univ. Hosp. Date signed 9-1-44

G20405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in Baltimore (yrs., mos., or days): 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Balto.
(c) City or town: Northeast Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 7118 Bristol Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3 (a) FULL NAME: LEO WINFIELD PATTERSON

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: 215-10-4056

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Patterson, Mildred

6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): 3-29-1898

8. AGE: Years: 46 | Months: 5 | Days: 1 | If less than one day: ____ hr. ____ min.

9. Birthplace: Fall River, Mass.
(Town, county, and state)

10. Usual Occupation: Department Chief

11. Industry or business: Western Electric Co

FATHER
12. Name: Patterson, John
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Ellen Herrington
15. Birthplace: Penna.

16 (a) Informant: Mrs. Mildred D. Patterson
(b) Address: 7118 Bristol Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-2-44 (month) (day) (year)

(c) Cemetery or crematory: Parkwood Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway-13

19 (a) (Date filed) SEP 2-1944 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8-30 1944; at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1944, to 8-30 1944, and that I last saw him alive on 8-30 1944.

Immediate cause of death: Coronary occlusion — Duration:
Due to: Arteriosclerosis
Due to: Heart Disease
Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Dwight Dill M.D.
Address: Church Home & Hosp. Date signed: 8-30-44

Dwight Dill MD.

G20406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20406 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 McCulloh St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Hall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1907

8. AGE: Years	Months	Days	If less than one day
41	11	7	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Ephraim Hall

13. Birthplace Md.

MOTHER 14. Maiden Name Sarah E. Davis

15. Birthplace Va.

16 (a) Informant Helen Johnson

(b) Address 1202 McCulloh St

17 (a) Burial (b) Date thereof 9-3-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Balto. Md.

18 (a) Funeral director Wm. A. Francis & H. Hemsley

(b) Address 1718 W. Biddle St.

SEP 2 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1944, at 2 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1944 to Aug 30 1944, and that I last saw h alive on Aug 30 1944

Immediate cause of death	Duration
Myocarditis	
Due to Rheumatic Heart Dis.	
Due to	
Other Conditions Mitral Stenosis & Chronic Nephritis.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address Provident Hospital Date signed 8/30/44 A. D.

G20407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G20407

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 8 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 N. Arlington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Achard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Dellie C. Achard
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1-22-88

8. AGE: Years 56 | Months 7 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual Occupation Postal Clerk

11. Industry or business

FATHER 12. Name James Riley

13. Birthplace (?)

MOTHER 14. Maiden Name Sarah Riley

15. Birthplace (Va)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4, '44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemaley
(b) Address 578 W. Biddle St.

19 SEP 2 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-31-1944 at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-3-1944 to 8-31-1944 and that I last saw him alive on 8-31-1944

Immediate cause of death: Cellulitis of back & Interveb due to A. welchii — Duration

Due to: Diabetic coma

Due to: cystitis

Other Conditions: generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation: Excision of gallbladder

Major findings of operation: terminal hypostasis pneumonia at prostate & tenesmus

of autopsy: prostatectomy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Burmingham M. D.
Address JHH Date signed 9/1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20408 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Fulmore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Ann Bates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7-1944

8. AGE: Years	Months	Days	If less than one day
	3	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Purcell S. Bates
13. Birthplace Virginia

MOTHER
14. Maiden Name Virginia Clemmons
15. Birthplace Maryland

16 (a) Informant Purcell S. Bates
(b) Address 1309 N. Fulmore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port

18 (a) Funeral director J. A. Brooks
(b) Address 1463 N. Carey St

19 (a) Sep 2 1944 [illegible] Washington Boulevard

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1944, at 6 1/2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944, to Sept 1 1944, and that I last saw h[illegible] alive on Sept 1, 1944.

Immediate cause of death Acute Gastritis — Duration

Due to Intoxication

Due to Malnutrition

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address [illegible] Hospital Date signed 9/2/44 M. D.

G20409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

G20409
Registered No.

RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayson & Fayette Sts.
(c) Hospital or institution: Bon Secour Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2021 W. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Elma A. Kirk — 206757

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Charles E. Kirk.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18th 1906

8. AGE: Years 37. Months 11 Days 14 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at home

FATHER
12. Name Otto C. Born
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Schueler
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Charles E. Kirk
(b) Address 2021 W. Saratoga St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/4/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Edgewood & Gwynndale Aves

18 (a) Funeral director Guy J. Conway & Son
(b) Address 901-903 Hollins St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
SEP 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 19 44, at 1 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15/44 to 9/1/44 and that I last saw her alive on 8/31/44

Immediate cause of death: Congestive Heart Failure — Duration: 17 days
Due to: Myocardial Disease
Due to: Post-Partum
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation Dec - 8/15/44
Major findings of operations:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas Norton, Jr.
Address Bon Secours Hosp. Date signed 9/1/44

G20410 BALTIMORE CITY HEALTH DEPARTMENT X G20410
Registered No.

CERTIFICATE OF DEATH 460

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Marys
(c) City or town St. Inigoes (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Chisley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Colored	Married

6 (b) Name of husband or ~~wife~~ James Chisley
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) June 25, 1884

8. AGE: Years	Months	Days	If less than one day
60	2	6	18 hr. 10 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Chisley
13. Birthplace

MOTHER
14. Maiden Name Teeny Curtis
15. Birthplace

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/44 (month) (day) (year)
(c) Cemetery or crematory St Peters
Location Ridge Md.
18 (a) Funeral director C. L. Robinson
(b) Address Leonardtown, Md.
19 (a) SEP 2 - 1944 (Date rec'd by registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1944, at 6 1/2 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 1944, to Sept. 1 1944, and that I last saw him alive on Sept. 1, 1944.

Immediate cause of death	Duration
Cardio respiratory failure	2 hrs.
Due to Carcinoma of Esophagus	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Aug. 28, 1944 & Aug. 31 1944
Major findings of operation: Carcinoma of esophagus
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature G. E. Hambsch M. D.
Address Mercy Hospital Date signed 9/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20411 G20411

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 429 E. 20th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 E. 20th. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Martin Hysan

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-9680

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 21-1865

8. AGE: Years	Months	Days	If less than one day
78	9	10	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. B. Hysan
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Georgianne Kelly
15. Birthplace Baltimore Md

16 (a) Informant Isabelle Farace Hysan
(b) Address 429 E 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 4-1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Joseph Farace Inc.
(b) Address 2013 Greenmount Ave.

19 (a) SEP 2 1944 Huntington, W. Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1944 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Aug. 31 1944, and that I last saw h alive on Aug 29 1944.

Immediate cause of death	Duration
Chronic Myocarditis	
Due to Hypertension & Arteriosclerosis	
Due to Mucous Colitis	6 Mo
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph Farace M. D.
Address 4411 Belleview Ave Date signed 9/1/1944

G20112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20112 / 1336

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 556 W. Baddale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-1
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 556 W. Baddale St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Bessie Russell

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Joe Wesson

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16-1903

8. AGE: Years 40 | Months 3 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace Surrey Co. Va.
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Matthews Russell
13. Birthplace Surrey Co. Va

MOTHER
14. Maiden Name Josephine Wandridge
15. Birthplace Surrey Co. Va.

16 (a) Informant Mrs. Josephine Russell
(b) Address 556 W. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location .....

18 (a) Funeral director Mrs Kate R Williams

(b) Address 3221 Lehmeday St

19 (a) SEP 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30 1944 at 10 30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Nephritis

.....

.....

Due to .....

.....

Other Conditions .....

.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury ..... M.

(b) Where did injury occur? .....

(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....

(d) Means of injury .....

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Aug. 30, 1944

G20413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 51B

G20413

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/31/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/31/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Sunny Bank (If outside city or town limits, write RURAL and give town)
(d) Street No. - (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY MARCELIOUS DAVENPORT

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Wid.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1875

8. AGE: Years 69 | Months 3 | Days 1 20 | If less than one day hr. min.

9. Birthplace No. Cumberland Co., Va. (Town, county, and state)

10. Usual Occupation Seaman - Mate

11. Industry or business SS MARY LOU

FATHER
12. Name James Davenport
13. Birthplace Va.

MOTHER
14. Maiden Name Lucy Bena
15. Birthplace Va.

16 (a) Informant Informant-Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-44 (month) (day) (year)
(c) Cemetery or crematory Lillian Va
Location Va

18 (a) Funeral director George G. Nelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 2 - 1944 Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1944, at 10:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31, 1944, to Sept. 1, 1944, and that I last saw him alive on Sept. 1, 1944.

Immediate cause of death 1. Adenocarcinoma of the prostate with generalized metastases; 2. Bilateral hydronephroses with uremia — Duration Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S Baker
Address Baltimore, Md. Date signed 9/1/44 M D

MS-54546

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 B

Registered No. G20414

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dickeland's Lazaret
(c) Hospital or institution: West Baltimore General Hospital 27-76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3413 Woodland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Norman Myers.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lauretta R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1881

8. AGE: Years	Months	Days	If less than one day
63	4	1	hr. min.

9. Birthplace Pleasant Valley Carroll Co., Md. (Town, county, and state)
10. Usual Occupation Checker - Navy Cost
11. Industry or business

FATHER
12. Name Levi Myers
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Fleagle
15. Birthplace Md.

16 (a) Informant Mrs. Lauretta R. Myers
(b) Address 3413 Woodland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

18 (b) SEP 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1944 at 7 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27 1944, to 9-1 1944, and that I last saw h/xx alive on 9-1 1944.

Immediate cause of death Pneumonia
Due to Carcinoma of liver
Due to Infected Rt hand & arm.

Duration

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Pneumonia lung abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address West Baltimore General Hosp. Date signed 9-1-44

G20415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH ✓ 95a

G20415

1. PLACE OF DEATH 304 Gittings Ave

Registered No. [illegible]

CITY OF BALTIMORE: (No. 304 E Gittings Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Miss Elizabeth H Gerlach

If U. S. Veteran specify WAR

(a) Residence: No. 304 E Gittings Ave. St., 27 Ward 12

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb. 12-1867

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77	6	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Carlsruhe Germany

FATHER

13. NAME Francis Gerlach

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME Lochlatz

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT Mrs. J. Milton Brault

(Address) 304 E. Gittings Ave

18. BURIAL, CREMATION, OR REMOVAL.

Place London Park Date , 19

19. UNDERTAKER Wm. H. Kyle & Son

(Address) 1924 E. Baltimore

SEP 2 - 1944 Huntington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Aug 31, 1944

22. I HEREBY CERTIFY, That I attended deceased from August 14, 1944, to August 31st, 1944

I last saw her alive on August 3d, 1944 Death is said to have occurred on the date stated above, at 11:55 AM

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis Fibrillation	
Other contributory causes of importance: Hypertension	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Eldred Roberts M. D.

(Address) 6100 York Road Baltimore Maryland

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. Every [illegible]

G20416

251330
251330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 55E

G20416 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or Institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Owings Mills
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Robert Kilbourne (Capt.)
3 (b) If veteran, name war: World
3 (c) Social Security Account No.: none
4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Jean Gibbons Kilbourne
6 (c) If alive, give age: 33 years
7. Birth date of deceased (mo., day, yr.): 12-17-91
8. AGE: Years 52 | Months 8 | Days 14 | If less than one day: hr. min.
9. Birthplace: New Bedford, Mass. (Town, county, and state)
10. Usual Occupation: Instructor
11. Industry or business: Johns Hopkins University

FATHER
12. Name: Arthur Kilbourne
13. Birthplace: England

MOTHER
14. Maiden Name: Maude Simpson
15. Birthplace: Scotland

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.
19 (a) Date received by Registrar: SEP 2 1944 (b) Registrar: Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1- 1944 at 12 25 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 5-18- 1944 to 9-1- 1944 and that I last saw him alive on 9-1- 1944

Immediate cause of death: Multiple abd. abscesses — Duration: 7 mos.
Due to: ?
Other Conditions: Lymphosarcoma — 2 yr?
(Include pregnancy within 3 months of death)
Date of operation 5/27/44
Major findings of operation: abd. abscess
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George J. Hayes
Address Johns Hopkins Hosp. Date signed 9/1/44

20417 T.C.P.-89591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G20417 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 33 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3030 Elliott Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert/or Adam/ Sibiski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1911

8. AGE: Years	Months	Days	If less than one day
32	8	16	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Merchant Marine

11. Industry or business

FATHER
12. Name George A.Sibiski
13. Birthplace Maryland

MOTHER
14. Maiden Name Tina ? (d)
15. Birthplace Poland

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) burial (b) Date thereof 9/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Foulkrod Inc.
(b) Address 10005 Reisterstown Rd.

SEP 2 1944 Huntington Williams, M.D.
(Date received) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1944 19..., at 4:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1944 to 8-31 1944 and that I last saw h[illegible] alive on 8-31 1944

Immediate cause of death sub-dural hematoma — Duration ?

Due to cause unknown

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. O'Leary, J.
Address City Hosp. Date signed 9-1 1944 M.D.

G20418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G20418

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 S. Robinson Sts
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 S. Robinson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie M. Seipert

3 (b) If veteran, name war

3 (c) Social Security Account No. No.

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis C.

6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) July 15 1889

8. AGE: Years 45 | Months 1 | Days 16 | If less than one day hr. min.

9. Birthplace Balto County
(Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Ernest Bartels

13. Birthplace Balto Co.

MOTHER 14. Maiden Name Kate Weaver

15. Birthplace Balto Co.

16 (a) Informant Louis C Seipert

(b) Address 211 S. Robinson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/44 (month) (day) (year)

(c) Cemetery or crematory Eastern Ave.

Location Oak Lawn

18 (a) Funeral director M. W. E. Dipp & Sons

(b) Address Lombard & Ann Sts.

19 SEP 2 - 1944 (Date rec'd by) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1944 at 12:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944 to Sept 1 1944, and that I last saw h. alive on Sept 1 1944.

	Duration
Immediate cause of death Pulmonary Oedema Cardiac Dilatation	7 days.
Due to	
Due to Cardio. Renal Dis.	7 yrs.
Other Conditions Ascites.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. N. Meyer
Address 1501 E. Fayette Date signed 9/1/44

G20419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G20419

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 Wellington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-6
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RUR and give town)
(d) Street No. 801 Wellington Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Curtis Dovell

3 (b) If veteran, name war —
3 (c) Social Security Account No. 213-10-1583
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Mary Elizabeth Dovell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 6-1883
8. AGE: Years 61 Months 6 Days 24 If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Baltimore Transit Co.
FATHER 12. Name George A. Dovell
13. Birthplace Virginia
MOTHER 14. Maiden Name Virginia C. Hepner
15. Birthplace Virginia
16 (a) Informant Mrs. Mary E. Dovell
(b) Address 801 Wellington Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 2-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland
18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road
19 SEP 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH August 30. 1944. at 4-40 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Aug 30 1944.
and that I last saw h[illegible] alive on Aug 28 1944.

Immediate cause of death: Squamous cell carcinoma right arrival region — Duration 1½ yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. N. Grenzer, M.D.
Address 1402 E. Lanvale St. Date signed 9-1-44

VS 180

G20420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

Registered No. G20420

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Ridgewood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2903 Ridgewood Ave. (If rural give location) 13
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Ford Yates

3 (b) If veteran, name war: no.
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Olive M. Yates
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 8 1868

8. AGE: Years 76 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace: Leonardtown Md. (Town, county, and state)

10. Usual Occupation: Conductor
11. Industry or business: Balto. Transit Co.

FATHER
12. Name: J. Frank Yates
13. Birthplace: St. Marys Co. Md.

MOTHER
14. Maiden Name: Sarah P. Yates
15. Birthplace: St. Marys Co. Md.

16 (a) Informant: Mrs. Olive M. Yates
(b) Address: 2903 Ridgewood ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 4 1944 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Balto. Md.

18 (a) Funeral director: C. Vernon Lemmon
(b) Address: 4611 Park Heights Ave

19 (Date received by registrar) SEP 2 - 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31 1944 at 11.30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22/44 19__, to 8/31/44 19__, and that I last saw him alive on 8/30/44 19__.

Immediate cause of death	Duration
Cerebral thrombosis	
Due to: Arteriosclerotic heart disease	
Due to: Broncho-pneumonia	
Other Conditions: Paralysis agitans	

(Include pregnancy within 3 months of death)

Date of operation --
Major findings of operation: --
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Krenger M.D.
Address 1428 Kingsway Rd. Date signed 8/31/44

G20421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20421 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: D.O.A.
(a) Baltimore City, Maryland
(b) Street address 645 N. Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 645 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Wilford a Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. 073-03-4830

4. Sex M

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 11. 1894

8. AGE: Years 49 | Months 9 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Silk spotter

11. Industry or business Dyeing.

FATHER
12. Name Rufus Brown
13. Birthplace North Carolina

MOTHER
14. Maiden Name Bettie Harper
15. Birthplace North Carolina

16 (a) Informant Roy Williamson
(b) Address 2502 Vendeventer Ave Raleigh N.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/29/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Thos. J. Kenny
(b) Address Hollins & Elmyk
(c) Huntington Williams, Md.

SEP 2 - 1944 (Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1944 at 11 30 P M

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Chester J. Zulinski M.D.
Medical Examiner.
Date signed 8/31/44

20422
XB-99588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. 20422

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 12-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2309 Maryland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Burke

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-30-1944

8. AGE: Years | Months | Days | If less than one day: hr. 45 min. min.

9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Marvin Price
13. Birthplace Md.

MOTHER
14. Maiden Name Eleanor Kapuscinski
15. Birthplace Mass.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave. (3.30 P.M.)

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 8-31-44 at (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records)

18 (a) Funeral director
(b) Address

19 SEP 2 - 1944 Date filed by Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30- 1944, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30- 1944 to 8-30- 1944, and that I last saw h. im alive on 8-30- 1944.

Immediate cause of death INTRACRANIAL Hemorrhage — Duration 1 hr.

Due to Version + Breech Extraction

Due to Premature Separation of Placenta

Other Conditions Prematurity 30 wks.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. B. Perry Jr. M.D.
Address Balto City Hosp Date signed 8/31/44

G20423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G20423 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County.....
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 2925 S. Buchanan St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John W. Haney, Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 11, 1936.

8. AGE: Years 8 | Months 1 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Pittsburg, Pa. (Town, county, and state)

10. Usual Occupation Schoolboy.

11. Industry or business

FATHER — 12. Name John P. Haney Sr.,
13. Birthplace —

MOTHER — 14. Maiden Name Harriet Mc Elroy,
15. Birthplace Pittsburg, Pa.

16 (a) Informant Mr. Father
(b) Address 2925 South Buchanan St. Arlington, Va.

17 (a) removal (Burial, cremation, or removal) (b) Date thereof 9/6/44. (month) (day) (year)
(c) Cemetery or crematory Pittsburg, Pa.
Location .....

18 (a) Funeral director Charles E. Schimpeler
(b) Address 1601-03 E. Madison St

19 SEP 2 - 1944 (Date rec'd by registrar) Arlington Va. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1944 at ..... M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Spleen and left Kidney

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury September 1 1944 7:45 P.M. 3/1
(b) Where did injury occur Eastern Shore Carolina
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Bus + auto collision

23. Signature Robert Lee Yeatman M.D. Medical Examiner.
Date signed September 2, 1944

G20424

BALTIMORE CITY DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

170C

Registered No. G20424

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County .....
(c) City or town Arlington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 S. Buchanan St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME: Harriet V. Haney

3 (b) If veteran, name war: none.

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: John P. Haney Sr.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 10, 1912.

8. AGE: Years 32 | Months 6 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Pittsburg Pa.
(Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name William Mc Elroy.
13. Birthplace Pitts. Pa.

MOTHER
14. Maiden Name Mary Daubner.
15. Birthplace Pitts, Pa.

16 (a) Informant husband
(b) Address 2928 South Buchanan, Street Arlington, Va.

17 (a) removal (b) Date thereof 9/6/44.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Pittsburg Pa.
Location .....

18 (a) Funeral director Harley E. Schimmel
(b) Address 601-03 E. Broadway, Street

19 (a) SEP 2 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1944, at 9 55 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to h an death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of pelvis; Hemorrhage Int. abdomen

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury September 1, 1944 3/1 745 P. M.

(b) Where did injury occur? Eastern Ave + Caroline

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Auto traffic collision

23. Signature Robert Lee Foster M.D.
Medical Examiner.

Date signed Sept 2, 1944

G20425 RAWLINGS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G20425

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 W. Mayetta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred P. Rawlings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife: Kate A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/2/1880

8. AGE: Years 64 | Months 1 | Days 29 | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Crane operator

11. Industry or business

FATHER
12. Name Ferdinand M Rawlings
13. Birthplace N. C.

MOTHER
14. Maiden Name Kate Taylor
15. Birthplace N C

16 (a) Informant Fred P. Rawlings Jr
(b) Address 620 Ripon Rd Alex. Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-2-44 (month) (day) (year)

(c) Cemetery or crematory
Location Rocky Mount N.C.

18 (a) Funeral director Geo. A Finley
(b) Address Fulton & Fayette

19 (a) SEP 2 1944 (b) Thurlington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1944, at 2 P 45 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenweber M.D.
Asst. Medical Examiner.

Date signed 9-1-44

G20426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

G20426 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette and John Streets
(c) Hospital or institution Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Parkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy PATTERSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31, 1944

8. AGE: Years	Months	Days	If less than one day
0	0	2	16 hrs. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Robert Patterson, jr.
13. Birthplace Dayton, Ohio

MOTHER
14. Maiden Name Isabel Carter
15. Birthplace Garrison, Maryland

16 (a) Informant Isabel Patterson, Mother
(b) Address 100 Univ. Parkway, Balto, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 2/44 (month) (day) (year)

(c) Cemetery or crematory St Thomas
Location Garrison forest Rd

18 (a) Funeral director Henry W. Jenkins Sons & McCullough Richardson
Address

SEP 3 - 1944
19 (a) (Date rec'd by registrar) (b) Huntington Williamson, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1944 at 5:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from August 31 1944 to Sept 2 1944 and that I last saw him alive on Sept 2 1944.

Immediate cause of death	Duration
Respiratory failure	2 hrs.
Due to Congenital heart disease	2 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marjorie J. Lewinson M. D.
Address Hosp. for Women of Md. Date signed 9-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given, and supplied if unknown. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20127 Registered No. 1578

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Cockeysville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peggy Marie Peterson

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 12 1944

8. AGE: Years	Months	Days	If less than one day
0	1	19	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Mr Vernon M Peterson
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella May Barron
15. Birthplace Maryland

16 (a) Informant Vernon M. Peterson
(b) Address Ashland, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 5 44 (month) (day) (year)
(c) Cemetery or crematory Poplar Methodist
Location Cockeysville, Md

18 (a) Funeral director Landon M. Brooks
(b) Address Sparks, Md.

SEP 3 1944 (b) Signature of [illegible] for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944 at 12 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 2 1944, and that I last saw her alive on Sept 2 1944.

Immediate cause of death	Duration
Atelectasis Failure	
Due to Pneumonia	
Due to Congenital heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Pneumonia, congenital heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Morris, M.D.
Address Ashland Md
M. D.
Date signed Sept 3 1944

G20428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20428 Registered No. 50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33-1 n Calvert St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 24 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. Hotel Alexander (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Kramer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maurice Joseph Kramer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20 1902

8. AGE: Years 42 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Illinois (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Stephenson
13. Birthplace Ottawa

MOTHER
14. Maiden Name Edith Hamilton
15. Birthplace Illinois

16 (a) Informant Maurice Joseph Kramer
(b) Address Hotel Alexander, Hagerstown, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9 (month) 5 (day) 44 (year)
(c) Cemetery or crematory
Location Hagerstown Md

18 (a) Funeral director A.R. Hoffman
(b) Address Hagerstown Md.
(c) SEP 3 - 1944 (Date received by registrar) Washington Williams Reg. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944 at 7:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 2 1944 and that I last saw h[illegible] alive on Sept 2 1944.

Immediate cause of death Cost. Peritonitis

Duration 6 hrs

Due to

Due to

Other Conditions Carcinomma of breast

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glenn P. Grove M. D.
Address Union Memorial Hosp Date signed 9-2-44

G20429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 B

G20429
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Frederick, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 124 W. Third Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Mildred D. Eastman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54	—	—	— hr. — min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Sales Clerk
11. Industry or business —

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Miss Elizabeth D. Eastman
(b) Address Frederick, Md.

17 (a) Burial (b) Date thereof Sept. 5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Olivet
Location Frederick - Md.

18 (a) Funeral director C. E. Clise + Son
(b) Address Frederick Md.

SEP 3 1944 (Date received by Registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/ 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1944, to 9/2 1944, and that I last saw h[illegible] alive on 9/2/ 1944.

Immediate cause of death	Duration
Cardio-Resp failure	
Due to Malignant Brain Tumor operation	
Due to metastasis to Brain	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9/2/44
Major findings of operation: Malignancy inoperable of brain
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Reid, Jr. M.D.
Address University Hosp. Date signed 9/2/44

G20430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20430 108 Reg. [redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Lansdowne (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 Willow Ave (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No) ✓
If yes, name country

3 (a) **FULL NAME** ~~Edward Self~~ Edward M. Self

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: W Widowed

6 (b) Name of husband or wife: Julia Self [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 19, 1873

8. AGE: Years 70 68 | Months 9 | Days 12 | If less than one day hr. min.

9. Birthplace Litchfield, Ill. (Town, county, and state)

10. Usual Occupation ~~Worker~~ Iron Moulder

11. Industry or business Lacey's Foundry

FATHER
12. Name Jasper Self
13. Birthplace Litchfield Illinois

MOTHER
14. Maiden Name ~~Mary Ann Murphy~~ Mary Murphy
15. Birthplace Illinois

16 (a) Informant P. J. Self
(b) Address 2618 Willow Ave, Lansdowne Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Memorial Pk Cem.
Location Hanover & Ga. Ave.

18 (a) Funeral director Willis Lawrence
(b) Address 1006 W. Baltimore St. Huntingtown Williams, Md.

19 [illegible] (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9·2 19 44, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8·30 19 44 to 9·[redacted] 19 44, and that I last saw him alive on 9·2 19 44

Immediate cause of death: Respiratory Crash — Duration

Due to: Pneumonia of Right lower lobe, and — Duration

Due to: Bronchopneumonia of left lung, Cerebral Sclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Rinehart
Address Univ. Hosp. Date signed M. 9·2·44 D.

G20431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G20431
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2519 Ellamont St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Shaver Taylor

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Joseph Milton Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 11, 1875

8. AGE: Years	Months	Days	If less than one day
69	7	20	hr. min.

9. Birthplace Friedens, Somerset Co., Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Oliver Perry Shaver
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elizabeth Walker
15. Birthplace Pennsylvania

16 (a) Informant Mr. Richard M. Taylor
(b) Address 2519 Ellamont St.

17 (a) Burial (b) Date thereof Sept 4, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Friedens Cem.
Location Friedens, Somerset Co., Pa.

18 (a) Funeral director Miller Funeral Home
(b) Address 4510 Liberty Heights Ave.

SEP 3 - 1944
(Date rec'd by registrar) (b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1944, at 6.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 17 1938 to Sept 1 1944, and that I last saw her alive on Aug 31 1944.

Immediate cause of death	Duration
1) Cerebral Hemorrhage	2 wks.
Due to Hypertensive Heart	
Due to Disease	- 6 yrs.
Other Conditions - Arteriosclerosis -	?

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Earl L. Chambers M. D.
Address 4108 Liberty Hgts Ave Date signed

G 20432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1816a

Registered No. G 20432

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green 15
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 4 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Allegany Pl.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lonelle Bent

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Rhone Bent

6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June - 1914

8. AGE: Years 30 | Months 3 2 | Days | If less than one day ____ hr. ____ min.

9. Birthplace Durham, (Town) N.C. (county, and state)

10. Usual Occupation Tob. Cal. Company

11. Industry or business

FATHER
12. Name Sep Lanier
13. Birthplace Durham. N.C.

MOTHER
14. Maiden Name Mary Allen
15. Birthplace Durham N.C.

16 (a) Informant Husband (Rhone Bent
(b) Address 709 Allegany Pl.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4, 1944 (month) (day) (year)

(c) Cemetery or crematory Durham
Location North Carolina

18 (a) Funeral director Mrs. Katie R Williams
(b) Address 322 N. Schroeder St.

19 (a) Sept. 3, 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 31st 1944, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 1st 1944 to Aug 31 1944, and that I last saw h[illegible] alive on Aug 31 1944.

Immediate cause of death Sub-Dural Hematoma — Duration

Due to Fall down Steps

Due to

Other Conditions Chronic Pannis Complicating Pregnancy
(Include pregnancy within 3 months of death)

Date of operation Aug. 31st - Trephine Dr.

Major findings of operation: Negative

of autopsy: Subdural Sac Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Fall down Steps
(b) Date of occurrence Aug. 14 at [illegible] M
(c) Where did injury occur? Home Baltimore Md (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —
(e) Means of injury Fall down Steps.

23. Signature [illegible] M. D.
Address University Hosp Date signed

Approved by Howard J. Thomas, M.D. Sept-1st 1944

G20433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

✓ G20433 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4618 Schley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4618 Schley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Kreisel

3 (b) If veteran, name war
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Otto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31. 1863

8. AGE: Years 80 | Months 10 | Days 1 | If less than one day: hr. min

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Julia Koehler
15. Birthplace Germany

16 (a) Informant Lorena Kreisel
(b) Address 4618 Schley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilson Lee Doe
(b) Address 1217 E Lanvale St

18 (c) SEP 8 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 1944 to 9-1 1944 and that I last saw her alive on 8/27 1944

Immediate cause of death	Duration
Cerebral hemorrhage	7
Due to Hypertensive Cardiovascular	?
Due to Disease	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation none
of autopsy: none performed

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis J. Jamieson, Jr.
Address 5129 Harford Rd Date signed 9/2/44

G20434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G20434 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3342 W. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George E Commo Sr

3 (b) If veteran, name war: I World War

3 (c) Social Security Account No. 212-09-8179

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife: Sophie M Commo.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 15, 1888

8. AGE: Years	Months	Days	If less than one day
56 54	4	2.1	7 hr. min.

9. Birthplace Spencer Mass.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Crown Cork + Seal Co

FATHER
12. Name William Commo.
13. Birthplace Vermont.

MOTHER
14. Maiden Name Marie La Bombard
15. Birthplace Canada.

16 (a) Informant Mrs Geo E. Commo.
(b) Address 3342 W Belvedere Ave

17 (a) Burial (b) Date thereof 9-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Pikesville Maryland

18 (a) Funeral director Long Bros.
Address 502 [illegible]

19 (a) SEP 3 - 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944, at 6-10 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage
Chronic Alcoholism
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Chester J. Lubinski M.D.
Medical Examiner.
Date signed 9/7/44

JL - 84208 G20435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c

G20435 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. B. C. H. Infirmary
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Perry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, ? 1861

8. AGE: Years 83 ? | Months ? 7 | Days ? 13 | If less than one day ... hr. ... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Frances
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Robinson
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) ... (Burial, cremation, or removal) (b) Date thereof 9 4 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Bergman Hill Road

18 (a) Funeral director John D. Fahey & Sons
(b) Address 1398 Light St.

SEP 8 1944 (Date registered) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1944 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-26-44 19 , to 5-29-19 44, and that I last saw h.. alive on 5-29-44 19

Immediate cause of death Pneumonia — Duration 12 days

Due to

Due to

Other Conditions Arteriosclerosis Parkinsonism
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W Kenneth Smith, MD

Address Balt. City Hosp Date signed 5/29/44 D.

G20436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G20436 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 Beaumont Ave
(c) Hospital or institution: Grace
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MA (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Beaumont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No) no
If yes, name country

3 (a) FULL NAME Ann C. Farrell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER

12. Name John Farrell

13. Birthplace Ireland

14. Maiden Name Mary Roche

15. Birthplace Ireland

16 (a) Informant Mary Farrell

(b) Address 535 Beaumont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/44 (month) (day) (year)

(c) Cemetery or crematory St Mary's

Location Emmitsburg Md

18 (a) Funeral director Chas. J. Tighe & Son

(b) Address 8 E Lexington St

SEP 3 1944

19 (a) (Date rec'd by registrar) (b) Washington Williamsport Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1944 at 8:03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1944 to Aug 31 1944 and that I last saw h[illegible] alive on Aug 31 1944

Immediate cause of death: Carcinoma of Liver and Gall Bladder

Duration: 6 months 2 weeks

Due to: Dehydration and Metabolic

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Albert Eisenberg

Address 2025 E Monument St Date signed 9/3/44

G20437 ✓ G20437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 W. University Pky
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltcity Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W University Pky (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Wright Mister

3 (b) If veteran, name war none | 3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Geo. T. Mister

6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) about May-27-1874

8. AGE: Years 70 | Months 3 | Days 6 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER 12. Name Charles Wright
13. Birthplace England

MOTHER 14. Maiden Name Susan H. Slicer
15. Birthplace Baltimore

16 (a) Informant Geo. T. Mister (Husband)
(b) Address 100 W University Pky

17 (a) entombment (Burial, cremation, or removal) (b) Date thereof Sept-4-44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore

18 (a) Funeral director Sherwood Memorial Co.
(b) Address 108 W Monument

19 (a) SEP 3 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1944, at 9 1/4 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10 Aug 1944 Sept 2 1944.
and that I last saw h[illegible] alive on Sept 1 1944.

Immediate cause: Coronary Occlusion — 2 Hrs.
Due to
Due to
Other conditions: Generalized Arteriosclerosis — Long
(Indicate pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jr. J. F. Slater Peck M.D. Jun Friedenwald
Address 1211 Eutaw Pl Date signed Sept 3 1944

G20438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G20438 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3826 Hudson Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3826 Hudson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas McAndrew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1888

8. AGE: Years 55 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Patrick McAndrew

13. Birthplace Balto., Md

MOTHER 14. Maiden Name Honora Henning

15. Birthplace Balto Co. Md.

16 (a) Informant Anna Mc Andrew

(b) Address 3826 Hudson St

17 (a) Burial (b) Date thereof Sept. 4-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Frederick Rd.

18 (a) Funeral director John A. Moran

(b) Address 3000 E. Baltimore St

19 (a) (b) Huntington Williams, M.D.
Registrar

SEP 3 1944

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1944, at 7 P. M

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallenweber M.D.
Medical Examiner.

Date signed 9-1-44

G20439
458 823

BALTIMORE CITY HEALTH DEPARTMENT ✓ X G20439

CERTIFICATE OF DEATH 7Ka

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Monument.
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore Town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 59 Berkeley Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia Ann Hurley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-19-39.

8. AGE: Years	Months	Days	If less than one day
4	9.	12	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Nelson Hurley.
13. Birthplace Pa.

MOTHER
14. Maiden Name Eleanor Fleckenschildt
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 4/44
(Burial, cremation, or removal) (Year)
(c) Cemetery or crematory Mt. Vernon. Balto.
Location Old Frederick Rd.

18 (a) Funeral director John A. McGuirk
(b) Address 4761 Greenmount Ave

SEP 3 - 1944 (b)
(Date accepted by Registrar) Registrar
Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 | 1 | 44 19 , at 8.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 | 31 19 44 to 9 | 1 19 44.
and that I last saw h. alive on 9 | 1 | 44 19

Immediate cause of death Heart failure.

Due to LEUKEMIA

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address The Johns Hopkins Hosp. Date signed 9-1-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

G20440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20440 Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4301 Liberty Hgts.
(c) Hospital or institution: Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3wks.
(e) Length of stay in Baltimore (yrs., mos., or days) " " "

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. Ebenezer Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Raphel Dandrea

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1880

8. AGE: Years	Months	Days	If less than one day
64	5 6	?	hr. min.

9. Birthplace Italy (town, county, and state)

10. Usual Occupation farm hand

11. Industry or business farming

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Aug. Unkart
(b) Address Middle River Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 5 44 (month) (day) (year)
(c) Cemetery or crematory Zion Luth. Cem.
Location Balto. Co. Md

18 (a) Funeral director Leonard Funeral Home
(b) Address 2401 Belair Rd.

9-7-1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3rd 1944 at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1944, to — 1944, and that I last saw h[e] alive on Sept 3 1944.

Immediate cause of death	Duration
Paralysis	1 day
Due to Heart Disease	1 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X (Specify type of place) While at work? X
(e) Means of injury X

23. Signature [illegible] M. D.
Address 2709 Edmondson Ave Date signed 9/7/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G20441 Registered No. G20441

CERTIFICATE OF DEATH 131a

G20441

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4606 Glenarm Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4606 Glenarm Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN T. NAGY

3 (b) If veteran, name war
3 (c) Social Security Account No. ***

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife John J. Nagy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1867

8. AGE: Years	Months	Days	If less than one day
76	8	7	hr. min.

9. Birthplace Hungary
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Obrovszky
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Eliz. Toston,
(b) Address 4606 Glenarm Ave.

17 (a) burial (b) Date thereof Sept. 4, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date received by registrar) (b) Harrington Williams M.D.

SEP 3 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1st, 1944 10:45P.M.

21. I certify that death occurred on the date above stated; that I last saw deceased from June 14 1944 to Sept. 1 1944
and that I last saw him alive on Sept. 1 1944

Immediate cause of death	Duration
Cerebral thrombosis	
Cystadenoma ovary	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Helen T. Nagy M.D.
Address 5707 Belair Rd. Date signed 9-2-44

G20442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G20442

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3601 Lake Montebello Drive (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Germany

3 (a) FULL NAME Miss Marie Bernauer

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: NONE

4. Sex: femal
5. Color or race: white
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: * *
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29, 1881

8. AGE: Years 63 | Months 1 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name Hamman Bernhuer
13. Birthplace GERMANY

MOTHER
14. Maiden Name Lens Deusheck
15. Birthplace GERMANY

16 (a) Informant Helen Gronberg
(b) Address 3601 Lake Montebello Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEPT. 4-1944 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location

18 (a) Funeral Director Chas. J. Evans Son, Inc.
(b) Address 118 W. Mt. Royal Ave.

19 SEP 4 - 1944 Hamilton Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1944, at 4 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1944 to 9-1 1944, and that I last saw her alive on 9-1 1944.

Immediate cause of death: CARDIO-RESPIRATORY FAILURE — Duration
Due to: Schwannoma
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23 Signature Hamilton F. VanLill M. D.
Address Union Memorial Hosp. Date signed 9-1-44

G20443

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20443

CERTIFICATE OF DEATH 55E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2916 Silver Hill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Emma E. Campbell

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 5, 1885

8. AGE: Years	Months	Days	If less than one day
59	2	29	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business

FATHER 12. Name Chaffy Campbell
13. Birthplace Md.

MOTHER 14. Maiden Name Martha Donahue
15. Birthplace Md.

16 (a) Informant Mrs. P. Grainger
(b) Address 2913 Silver Hill Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6, 44 (month) (day) (year)
(c) Cemetery or crematory Asbury Mem.
Location Perryville, Md. Rural

18 (a) Funeral director H. A. Patterson & Son
(b) Address Perryville, Md.

19 SEP 4 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1944 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/28 1944 to 9/3 1944 and that I last saw her alive on 9/3 1944

Immediate cause of death Generalized Carcinomatosis

	Duration
Due to.....	.....
Due to.....	.....
Other Conditions.....	.....

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation: None
of autopsy: Generalized Carcinomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M.
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature J. Earl Myers
Address Md. Gen. Hosp. Date signed 9/3/44

G20444 T.G.P.-89324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G20444

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 217 North High Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dan Ingram

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1, 1879

8. AGE: Years	Months	Days	If less than one day
65	4 3	0	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Steamfitter
11. Industry or business

FATHER
12. Name William James Ingram
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Rachael ?
15. Birthplace Pennsylvania

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Uniondale Cem.
Location Pittsburg, Penna.

18 (a) Funeral director Eastern Sons
(b) Address Ellicott City, Md.

19 SEP 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1944, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8 1944, to 9-1 1944, and that I last saw him alive on 9-1 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration 7 mos

Due to

Due to

Other Conditions Gen. arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Kenneth Smith
Address Balt. City Hosp. Date signed 9/3/44

G20445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1159

Registered No. G20445

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Lexington Sts
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2313 Frederick Ave (If rural give location)
(e) Citizen of foreign country? Md (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Wright

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3, 1944

8. AGE: Years	Months	Days	If less than one day
			6 hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Ernest H. Wright Jr.
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Margaret Robertson
15. Birthplace Balto. Md

16 (a) Informant Mrs. Mary. Wright
(b) Address 2313 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Balto. Md

18 (a) Funeral director George A. Forbes
(b) Address Fayette & Fulton Sts

19 SEP 4 - 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3, 1944 at 12 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1944 to 9/3 1944, and that I last saw h[illegible] alive on 9/3 1944.

Immediate cause of death Atelectasis — Duration

Due to —

Due to —

Other Conditions Prematurely 28-3 oz wks
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Robert B. Tunney M. D.
Address Mercy Hosp Date signed 9/5/44

G20446

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20446
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 151 S. Monastery Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 151 S. Monastery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Kremer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widow

6 (b) Name of husband or wife Ellen B

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1872

8. AGE: Years	Months	Days	If less than one day
72	7	26	hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Edward Christopher Kremer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Louise Gable
15. Birthplace Germany

16 (a) Informant Laurence A. Kremer
(b) Address 12 Longwood Ave

17 (a) Burial (b) Date thereof 9-3-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic Cem
Location Baltimore Md

18 (a) Funeral director George L. Farley
(b) Address Fulton & Fayette

19 (a) SEP 4 - 1944 Huntington Williams, Md.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944 at 20 P M

21. I certify that I took charge of the remains described above, held an Inquiry - Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Myocardial Degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Wilton F. Tulbirbe M.D.
Medical Examiner.
Date signed 9/2/44

G20447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1316

G20447 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland N.
(b) Street address 904 N. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 Eutaw St. N. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Thompson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day: hr.	min.
58				

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace N. C.

MOTHER
14. Maiden Name Littlejohn
15. Birthplace S. C.

16 (a) Informant Eileen Rice
(b) Address 904 Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Spartanburg S. C.

18 (a) Funeral director A. Galyean
(b) Address 918 Druid Hill Ave

19 SEP 4 1944 Huntington-Williams, Mgr.
(Date received by Local Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1944 to Sept 2 1944 and that I last saw h[illegible] alive on Aug 31 19

Immediate cause of death Chronic Nephritis — Duration One year

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Pelletreau M. D.
Address 817 Hamilton Ave Date signed Sept 7/44

WW G20448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G20448

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 Carson Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Scott

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Richmond, Va. (Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ..

MOTHER
14. Maiden Name Unknown
15. Birthplace ..

16 (a) Informant Emma Jones
(b) Address 1104 Carson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Geo. B. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1, 1944 at 12 noon M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

(Signature) H. L. Wallenmeyer M.D.
Medical Examiner.

Date signed 9-1-44

G20449

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 520 G20449

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345 Stricker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 N. Stricker
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Celestine Hammond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John Hammond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day: hr. min.

9. Birthplace Danville Virginia
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. Preston Watkins

13. Birthplace Va

MOTHER 14. Maiden Name L. Scott

15. Birthplace Va

16 (a) Informant John Hammond

(b) Address 1345 N. Stricker St

17 (a) Burial (b) Date thereof 9-7-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location Md

18 (a) Funeral director George G. Nelson

(b) Address 1303 Presstman St

SEP 4 1944 (Date received) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/31 1944 at 2:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1944 to 8/31 1944, and that I last saw him alive on 8/29 1944.

Immediate cause of death	Duration
Carcinoma of left breast	7
Due to Hypernephroma	
Due to Metastasis to lungs.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. R. Julian

Address 434 E. 23rd St Date signed 9-7-44

VS 150

G20450 Bens

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G20450 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1430 N Mount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~30 yrs~~ 562
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1430 N Mount Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Shirley Bens

3 (b) If veteran, name war

3 (c) Social Security Account No. 205-09-6352

4. Sex Male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sophia Bens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/1875

8. AGE: Years 68 | Months 11 | Days 22 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Sophia Bens

(b) Address 1430 N. Mount Ave

17 (a) Burial (b) Date thereof 9-5-44 (month) (day) (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Wes. H. Kelbaugh

(b) Address 1303 Pennsylvania Ave

SEP 4 1944 (b) Huntington Wilkinson, M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1944, at 6 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944 to 9/1 1944, and that I last saw h~~e~~ alive on 9/1 1944

Immediate cause of death	Duration
Cardiovascular Renal disease, Hypertension	14 yr
Due to Uremic Coma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Nature of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 9/1/44

G20451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

G20451 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2456 Brent Woodave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2456 Brent Woodave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Williams Parker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife George Parker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 19/1918

8. AGE: Years	Months	Days	If less than one day
26	5	12	hr. min.

9. Birthplace Baltimore
(Town, county and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Robert Williams
13. Birthplace Md

MOTHER
14. Maiden Name Elnora Kelly
15. Birthplace Md

16 (a) Informant George Parker
(b) Address 2456 Brent Woodave

17 (a) Burial (b) Date thereof 9-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 412 E. Preston St

19 SEP 4 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 1944 at 7:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1944 to Aug 31 1944, and that I last saw h[illegible] alive on Aug 29 1944.

Immediate cause of death

Uremia Nephritis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration
6 hrs.
5 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis J. Schwartz M. D.
Address 2329 Gemaps St Date signed Aug 31 1944

G 20452

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20152

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: JOHN HOPKINS
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 HRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Sparrows Point (If outside city or town limits, write RURAL and give town)
(d) Street No. 230 & Old Range Farm Road. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stuart Collier

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. NONE

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: SINGLE
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 6 1944

8. AGE: Years | Months: 5 | Days: 26 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name Stuart Collier
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Hochberbung.
15. Birthplace Pa.

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 5/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE EXT.

18 (a) Funeral director Lilly and Geiler Inc.
(b) Address 403 S. WOLFE ST.

19 Date rec'd by local registrar SEP 4 - 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-2- 1944, at 2.45 A/M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-2- 1944 to Sept-2- 1944, and that I last saw him alive on Sept-2- 1944.

Immediate cause of death Respiratory collapse — Duration: about 5 Days
Due to Acidosis
Due to Summer Diarrhea
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Leonard Jed Hoag M. D.
Address Johns Hopkins Hosp Date signed 9-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G20453 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1734 LANCASTER ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days) 85 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE MD.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1734 LANCASTER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE KEYS

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: JOSEPH F. KEYS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 8 1859

8. AGE: Years 86 | Months 2 3 | Days 25 | If less than one day hr. min.

9. Birthplace PENNA. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name ADAM HINES
13. Birthplace GERMANY

MOTHER
14. Maiden Name ELIZABETH FREDERICK
15. Birthplace GERMANY

16 (a) Informant LENA HINES (NEICE)
(b) Address 1734 LANCASTER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 5/44 (month) (day) (year)
(c) Cemetery or crematory SCHWARTZ
Location ODONNELL ST.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S. WOLFE ST. Huntington Williams, M.D.

19 SEP 4 - 1944 (b) (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 2 1944, at 12 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 1 1944 to Sept. 2 1944 and that I last saw h[illegible] alive on [illegible] 1944.

Immediate cause of death: Acute Cardio-Vascular Failure
Due to: Chr. Endocarditis + Myocarditis
Due to: Chr. Arterio-Sclerosis
Other Conditions: Fracture of L Femur
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
2 days
?
?
10 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence December 1943 A.M.
(c) Where did injury occur? 1734 Lancaster St.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Fractured Left Hip
23. Signature [illegible]
Address [illegible] Date signed 9/3/44 M. D.

approved by Howard D. Mudens, M.D.

G20454

DONALD

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 520

G20454 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West. Balt Gen. Hosp. Rayner Ave & Lakeland St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1728 Harford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

9-9

3 (a) FULL NAME Mrs. Mamie E. Donald.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Morris Donald

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 47 | Months | Days | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Julius Brauer

13. Birthplace Lith

MOTHER 14. Maiden Name Ida -

15. Birthplace Lith

16 (a) Informant Morris Donald

(b) Address 1728 Harford Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jacob Myers Inc

(b) Address 1431 E. Balto. St

19 (a) SEP 4 - 1944 (Date rec'd by registrar) Huntington Williams Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 2 1944, at 11.57 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5 31 1944 to 9 2 1944 and that I last saw h[illegible] alive on 9 2 1944

Immediate cause of death Cancer of Gall Bladder

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 3 mos 9 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.

Address West Baltimore General Hosp Date signed 9-3-44

G20455987
B29987

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 13B

Registered No. G20455

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: John Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Texas (b) County
(c) City or town: Pasedena (If outside city or town limits, write RURAL and give town)
(d) Street No. Box 10008 Pasedena (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bert Hamrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-99

8. AGE: Years	Months	Days	If less than one day: hr.	min.
44	9	27		

9. Birthplace KANSAS (Town, county, and state)

10. Usual Occupation Enginear (Marine)

11. Industry or business

FATHER 12. Name Wyatt Hamrick
13. Birthplace Ohio

MOTHER 14. Maiden Name Carrie Oyler
15. Birthplace Ohio

16 (a) Informant record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 4/1944 (month) (day) (year)
(c) Cemetery or crematory Hansford, Texas
Location

18 (a) Funeral director John D. Mitchell Undertaking Co
(b) Address 1900 Eutaw St

19 SEP 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, Mgr. Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1944, at 1:19 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-28 1944 to 9-3 1944, and that I last saw h[illegible] alive on 9-3 1944

Immediate cause of death Pulmonary hemorrhage — Duration

Due to T.B.C. Pulmonary

Due to

Other Conditions 1st & 2nd Stage Laryngeal T.B.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Burnside, M. D.
Address J. H. H. Date signed 9-3-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20456

Sinwell

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G20456 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~6508 Kemper Road~~
(c) Hospital or institution: 6001 Belloma Ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 15 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6508 Kemper Road (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No) If yes, name country

3 (a) FULL NAME William Sinwell

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Alice R. Sinwell

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 26 1868

8. AGE: Years 76 | Months 6 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Real Estate

11. Industry or business

FATHER
12. Name John Sinwell
13. Birthplace Germany

MOTHER
14. Maiden Name Christine Hetzen
15. Birthplace Germany

16 (a) Informant Paul Jr. Sinwell
(b) Address 5508 Kemper Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6 1944 (month) (day) (year)
(c) Cemetery or crematory Fountain Hill Cem. Assn.
Location Bethlehem Pa.

18 (a) Funeral director John A. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 SEP 4 - 1944 (Registrar's signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1944, at 5.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13 1944 to Sept 3 1944, and that I last saw h/[illegible] alive on Sept 3 1944

	Duration
Immediate cause of death Myocardial Insufficiency	2 days
Due to Cerebral Hemorrhage	21 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davis M. D.
Address 800 N. 33rd St Date signed 9/3/44

G20457

G20457

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1938

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Catonsville Ave
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5107 Fredrick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arabella E. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1870

8. AGE: Years 73 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Wm. Baker
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Wilhelmina Durham
15. Birthplace Balto. Md.

16 (a) Informant Emma M. Baker
(b) Address 5107 Fredrick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave. Balto. Md.

18 (a) Funeral director John O. Mitchell Funeral Inc.
(b) Address 1900 Eutaw P.L.

19. SEP 4 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1944 at 5:20 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1944 to 9-2 1944 and that I last saw h.r. alive on 9-1 1944

Immediate cause of death Pulmonary Edema — Duration

Due to Hypertensive C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.

Address St. Agnes Hosp Date signed 9-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Do not abbreviate. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

20458 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 20458

CERTIFICATE OF DEATH 830a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2710 N. Calvert St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 89 yrs. 11 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran specify WAR

2. FULL NAME Helena McColgan

(a) Residence: No. 2710 N. Calvert St., 12-3 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Oct. 2, 1854

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
89	11	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

FATHER

13. NAME Charles C. McColgan

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME Ann Gallagher

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Mr. Charles C. McColgan

(Address) 2710 N. Calvert St.

18. BURIAL, CREMATION, OR REMOVAL

Place Cathedral Cem Date 9/5/44 19

19. UNDERTAKER H. W. Meamtow

(Address) 805 N. Calvert St.

20. SEP 4 - 1944 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) September 2 1944

22. I HEREBY CERTIFY, That I attended deceased from August 31 1944 to September 2 1944

I last saw h.. alive on September 2, 1944 Death is said to have occurred on the date stated above, at 10:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Generalized arteriosclerosis	1930
Cerebral hemorrhage	9/2/44

Other contributory causes of importance:

Was an operation performed? Yes Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

No If so, specify

(Signed) Edward J. C. Walzl M. D.

(Address) 532 N. Washington St

Edw. M. Walzl, M.D.

N. B.—WRITE PLAINLY. THE ONE HEADING INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact OCCUPATION is very important. See instructions on back of certificate.

G20159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G20159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 N. Appleton St.
(c) Hospital or institution:

16-4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N. Appleton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENKINS F. GRANGER (Felix J. Granger)

3 (b) If veteran, name war: --
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ella V. Granger
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 16, 1873

8. AGE: Years	Months	Days	If less than one day
71	0	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Daniel Miller Co.

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Ann --
15. Birthplace Va.

16 (a) Informant Mrs. Ella V. Granger
(b) Address 904 N. Appleton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Washington Williams, M.D.

19 (a) SEP 4 - 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 2, 1944, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1944 Sept 2 1944, and that I last saw h. alive on Sept 1, 1944

Immediate cause of death	Duration
Coronary Occlusion	1 day
Due to Arteriosclerosis	??
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature H. C. Williams M.D.
Address 2757 W. North Ave. Date signed 9/2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

620160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. 620160

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Mt. Sin. Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3d
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto. 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2444 Clifton Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Wm. R. Spurrier

3 (b) If veteran, name war: none
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. 213-03-4408

6 (b) Name of husband or wife Sophia V. Spurrier
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 20 1882

8. AGE: Years 62 | Months 4 | Days 2 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Balto. Gas Light Co.

FATHER — 12. Name Harry Spurrier
13. Birthplace Md.

MOTHER — 14. Maiden Name Lizzie V. Chenoweth
15. Birthplace Md.

16 (a) Informant Sophia V. Spurrier
(b) Address 2444 Clifton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 4 - 1944 (Date rec'd) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 19 44 at 7 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 19 44 to 9/2 19 44 and that I last saw h.. alive on 9/2 19 44

Immediate cause of death	Duration
Cerebral hemorrhage	
accident	
Due to.....	
Due to.....	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:.....
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?.....
(e) Means of injury.....

23. Signature H. Coit Myers M.D.
Address Md. Gen. Hosp. Date signed 9-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C20461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C20461

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 Ramsey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John William Hooker

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 26, 1943

8. AGE: Years	Months	Days	If less than one day
1	0	5	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John J. Hooker
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Dorothy Tompson
15. Birthplace Balto., Md.

16 (a) Informant Mr. John J. Hooker
(b) Address 1910 Ramsey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 4 - 1944 (Date rec'd by Local Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1944 at 8:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1944 to 9/1 1944 and that I last saw him alive on 9/1 1944

Immediate cause of death: Non-Specific Diarrhoea — Duration: 9 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Path. Histologic

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Sigmund Rosen, M. D.
Address 1911 Eutaw Pl. Signed 9/1/44

VS 150

620462 NOLAND X 620462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Stret.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Dundalk ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie M Noland

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. 215-07-9358

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Rose M. Noland
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31-1901

8. AGE: Years	Months	Days	If less than one day
43	0	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Secy-Treas.
11. Industry or business Steamship Service Corp.

FATHER
12. Name George E. Noland
13. Birthplace Maryland

MOTHER
14. Maiden Name Maude Chaney
15. Birthplace Maryland

16 (a) Informant Mrs. Rose M. Noland
(b) Address 100 Dundalk Ave-Dundalk, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6th 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves-Baltimore, Md.

19 (a) SEP 4 - 1944 (Date Rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2-44 19 , at 11 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1944 to 9-2 1944 and that I last saw h[illegible] alive on 9-2 19 44

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St. Date signed 9-2-44

STEINBACH

G20463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1220

G20463 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 1503
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Warwick Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick J. Steinbach

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Elise M. Steinbach
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): April 3, 1879
8. AGE: Years 65 | Months 5 | Days 0 | If less than one day hr. min.
9. Birthplace: Melsungen Germany (Town, county, and state)
10. Usual Occupation: Bakery
11. Industry or business: Self

FATHER
12. Name: Conrad Steinbach
13. Birthplace: Melsungen Germany

MOTHER
14. Maiden Name: Gertrude A. Deitrich
15. Birthplace: Melsungen, Germany

16 (a) Informant: Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6, 1944 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: Baltimore, Md.
18 (a) Funeral director: Wm. J. Tirlmar & Sons,
(b) Address: North & Pa. Aves.
19 (a)

SEP 4 - 1944 (Date rec'd by registrar)

Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1944, at 6 A. M.
21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1944, to 9/3 1944, and that I last saw h.i.m. alive on 9/3 1944.

Immediate cause of death: Retroperitoneal hemorrhage — Duration
Due to: Probably an aneurism
Due to: basis (rupture)
Other Conditions: 8th day P.O. hemiplegia
(Include pregnancy within 3 months of death)

Date of operation 8/25/44
Major findings of operation: Left inv. hemiplegia
of autopsy: Retro peritoneal hemorrhage

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature F. W. Traymor
Address Md. General Hosp. Date signed 9/3/44 M. D.
F. W. Traymor

G20464

MARYLAND STATE DEPARTMENT OF HEALTH

CITY 2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 13B

Reg. Dist. No.

G20464

1. PLACE OF DEATH:

County

City or town BALTO., MD.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 5312 WINNER AVE.

Stay in hospital or inst. (yrs., or mos., or days) 27 D

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County

City or town BALTIMORE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 5312 WINNER AVE.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME PHILIP HASCHERT

3. (b) Social Security Number ?705-05-777

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife VIOLA A. HASCHERT

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 20, 1877

8. AGE: Years	Months	Days	If less than one day
67	3	11	hrs. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual occupation RETIRED CLERK

11. Industry or business B. & O. R. R. Co.

FATHER 12. Name LEONARD P. HASCHERT

13. Birthplace BALTO., MD.

MOTHER 14. Maiden name MARY HOCKELTON

15. Birthplace BALTIMORE, MD.

16. Informant MRS. ELIZABETH SCHROEN

Address 5312 WINNER AVE.

17. BURIAL Date thereof 9-4-44
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory BALTO., CEM.

Location BALTO., MD.

18. Funeral director WM. J. TICKNER & SONS.

Address BALTO., MD.

19. SEP 4 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1-44 19 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-1-44 19 to 9-1-44 19

and that I last saw him alive on 8-31-44 19

Immediate cause of death	DURATION
Pulmonary Intoxication	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James M. Gaffell M.D. or other

Address Westminster Md Date signed 9/2/44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20465
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1643 Wolkens av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 9th
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs ~~40 yrs~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Wolkens av
(If rural give location)
(e) If foreign born, how long in U. S. A.? 33 yrs years

3 (a) FULL NAME Susanna Birkenheier

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Nicholas Birkenheier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11th 1878

8. AGE: Years	Months	Days	If less than one day
66	-	21	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation House work
11. Industry or business —

FATHER
12. Name Nickolas Birkenheier
13. Birthplace Austria

MOTHER
14. Maiden Name —
15. Birthplace Austria

16 (a) Informant Marie Beringer
(b) Address 1643 Wolkens Av

17 (a) (Burial, cremation, or removal) (b) Date thereof 9th 6th 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Elden

18 (a) Funeral director A. Jones
(b) Address 111 S. Gilmor st

19 (Date received by registrar) SEP 4 - 1944 Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 19 44 at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 19 44 to 9/2 19 44 and that I last saw h~~e~~r alive on 9/2 19 44.

Immediate cause of death Coronary sclerosis — Duration 6 hours

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Benjamin Welker M. D.
Address 930 Wilkens Date signed 9/3/44

G20466

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1213

G20466 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 832 N. Carey
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 N. Carey (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florida L. Pettigrew

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: 60 years | Months | Days | If less than one day hr. min.

9. Birthplace Glaucester Co. Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or Business

FATHER 12. Name Jas. Williams
13. Birthplace Va

MOTHER 14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Marie Pettigrew
(b) Address 832 N. Carey St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/6/44 (month) (day) (year)
(c) Cemetery or crematory Arlington
Location Balto Co.

18 (a) Funeral director Mrs. Geo. H. Holland
(b) Address 1631 West Fayette St.

19 (a) SEP 4 1944 (b) Huntington Williams M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3, 1944 at 10 a, M

21. I certify that death occurred on the date above stated, that I attended deceased from 2/1 1944 to 9/3 1944, and that I last saw her alive on 9/2 1944

Immediate cause of death Chr. nephritis — Duration 7 yrs

Due to

Due to

Other Conditions Chr. Val. H.D. — Duration "

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. D. Layton

Address 1522 Harlem Ave signed 9/4/44

G20467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G20467

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 428 E. Federal St.

(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 428 E. Federal (If rural give location)

(e) Citizen of foreign country? (Yes or No) ✓

If yes, name country

3 (a) FULL NAME Robert Banks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1882

8. AGE: Years 62 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Expressman

FATHER 12. Name Robert Banks

13. Birthplace

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Alex Baks

(b) Address 428 Federal St

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/6/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet

Location Balto City

18 (a) Funeral director Mr Geo A Hellard

(b) Address 1631 Hanover Ave

19 (a) Date received by local registrar SEP 4 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2-44 at 6:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15 1944 to 9-2-1944 and that I last saw h[illegible] alive on 9-2-1944

Immediate cause of death: (a) Bronchio-Pneumonia — Duration 7 days

Due to: (b) Pleurisy Bilateral — 10 days

Due to: (c) Pericarditis — 10 days

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Isaac D Blake M. D.

Address 1327 N Central Ave Date signed 9/4/44

G20468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 46E

Registered No. G20468

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 Cloney St-Dsn.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Cloney St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Tasker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Holmes
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ida Taylor
15. Birthplace Balto. Md

16 (a) Informant George Tasker
(b) Address 1007 Cloney St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-4-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus - Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Paca St Huntington Williams, M.D.

19 SEP 4 - 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1944 at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to Palsy

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester J. Lubinski M.D. Medical Examiner.
Date signed 8/30/44

VS 151

G20169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

#8b

Registered No. G20469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 405 N. Pulaski St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 N. Pulaski St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olga Levina Lepson

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Howard J. Lepson
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) July 29, 1884

8. AGE: Years	Months	Days	If less than one day
60	1	2	hr. min.

9. Birthplace Baltimore? Md.
(Town, county, and state)
10. Usual Occupation Home Duties
11. Industry or business

FATHER
12. Name Charles Lupus
13. Birthplace Baltimore

MOTHER
14. Maiden Name Ida VonDrehle
15. Birthplace Baltimore

16 (a) Informant Mr. Howard J. Lepson
(b) Address 405 N. Pulaski St.

17 (a) Burial (b) Date thereof 9-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director Yaeger & Adler
(b) Address 1200 N. Lombard St.

19 (a) (b) Huntington Williams, M.D.
(Date received by Local Registrar) (Registrar)
SEP 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31st 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to Aug 31 1944, and that I last saw h. alive on Aug 30 1944.

Immediate cause of death — Duration

Carcinoma of Uterus — 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature Chas A Cahn M. D.
Address 2145 N Bolton St Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Bey Kader
2306 Eutaw Place

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46L

Registered No. G20470

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 943 N. Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 943 N. Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Barbara C. Kaperaleka

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph G. Kaperaleka

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1875

8. AGE: Years 68 | Months 9 | Days 30 | If less than one day: 24 hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Joseph Zelenka
13. Birthplace Bohemia

MOTHER
14. Maiden Name Emma Student
15. Birthplace Bohemia

16 (a) Informant Joseph G. Kaperaleka
(b) Address 3260 Lochsaven Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director Frank Brochhorst
(b) Address 20 E. Chester St.

19 (a) SEP 5 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 2 1944, at 3:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 25 1944 to Sept 2 1944, and that I last saw h-- alive on Sept. 2 1944

Immediate cause of death: Carcinoma of Sigmoid, diabetes mellitus — Duration

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bey: Kader M. D.

Address 2306 Eutaw Pl Date signed 9-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

H6d

Registered No. G20471

G20471

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 53rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Churchville
(If outside city or town limits, write RURAL and give town)
(d) Street No. P.O. Aberdeen RFD #2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bennett H. Barnes

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1857

8. AGE: Years	Months	Days	If less than one day
87	2	20	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Farmer

FATHER
12. Name Aaron Barnes
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah Dillon
15. Birthplace Maryland

16 (a) Informant Miss Margeta Barnes
(b) Address Bernard, Maryland

17 (a) Burial (b) Date thereof 9/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Churchville Cem.
Location Harford Co. Md

18 (a) Funeral director H. S. Bailey
(b) Address Darlington Md.

SEP 5 1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1944, at 3:37 A M

21. I certify that death occurred on the date above stated; that I attended deceased from August 22 1944 to Sept 5 1944, and that I last saw h[illegible] alive on 9-4 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	1 wk.
Due to Carcinoma of rectum & pelvic metastases	yrs.
Due to	
Other Conditions Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John D. Morris, M.D.
M. D.
Address [illegible] MH. Date signed Sept 5, 44

G20472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 21

Registered No. G20472

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Evans Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Margaret M Fraley

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 18, 1878

8. AGE: Years 66 | Months 2 | Days 16 | If less than one day: 8 hr. 45 min.

9. Birthplace Pa.
(Town, county, and state)

10. Usual Occupation housework
11. Industry or business Home.

FATHER
12. Name George Hughes
13. Birthplace Penna.

MOTHER
14. Maiden Name Maria Snyder
15. Birthplace Penna

16 (a) Informant Mrs. Maria Nevel
(b) Address 1010 Evans Way.

17 (a) Burial, cremation, or removal: Burial (b) Date thereof 9/6/44
(month) (day) (year)
(c) Cemetery or crematory PLEASANT HILL
Location HUGHESVILLE, Pa.

18 (a) Funeral director Fullerton Lord & Inc
(b) Address 1219 St Paul St

SEP 5 - 1944 (b) Huntington Williams M.D.
(Date rec'd by Reg. of Vr.)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944, at 9:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30, 1944 to Sept 4 1944, and that I last saw he alive on Sept 4 1944

	Duration
Immediate cause of death: Circulatory collapse	36 hr.
Due to: Generalized Peritonitis	5 days.
Due to: Perforated appendicitis	6 days.
Other Conditions: Chronic appendicitis & Acute Peritonitis	

(Include pregnancy within 3 months of death)

Date of operation Aug 30, 1944

Major findings of operation: Perforated appendix & peritonitis

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert J. Berry M.D.
Address Calvert & Saratoga Sts Date signed 9/4/44
Mercy Hospital

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20473 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 Edgeworth Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rebecca Gilman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Nathan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Russia (town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Aaron Eyler

13. Birthplace Russia

MOTHER 14. Maiden Name Hilda Floma

15. Birthplace Russia

16 (a) Informant Nathan Gilman

(b) Address 2422 Edgeworth ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5/44 (month, day, year)

(c) Cemetery or crematory Beth Tfiloh Cemetery

Location Windsor Mill Road

18 (a) Funeral director Sol Levinson Bros.

(b) Address 1124-26 W. North ave

SEP 5 - 1944 (b) Huntington Williams, M.D.
(Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4 1944, at 8:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/16 1944 to 9/4 1944, and that I last saw h alive on 9-4 1944.

Immediate cause of death Cardiac failure

Due to Post operative Pneumonia

Due to Ruptured appendix

Other Conditions Peritonitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A.A. Gryffin M. D.

Address St Agnes Hosp. Date signed

G20474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G20474

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 329
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2618 St. Paul St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME [illegible] Portman (Margaret Mae)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Frederick Portman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 39 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace Tennessee (Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business

FATHER
12. Name Thomas Evans
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary Watson
15. Birthplace Kentucky

16 (a) Informant HOSPITAL RECORDS
(b) Address Union Memorial Hosp

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory St Marys
Location Hampden Baltimore Md

18 (a) Funeral director Wilhelm Bros Inc
(b) Address 1219 E Pratt St

SEP 5 — 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1944, at 9:55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11 1943 to 9-3 1944, and that I last saw her alive on 9-3 1944.

	Duration
Immediate cause of death C-R Failure	
Due to Generalized CA ? Abdomen	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen L Mayfield M. D.
Address Union Memorial Hosp Date signed 9-3-44

G20475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 47D

Registered No. G20475

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/3/44
(e) Length of stay in Baltimore (yrs., mos., or days) " 8/3/44

2. USUAL RESIDENCE OF DECEASED:
(a) State New York (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 75 E. Third Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME EVARISTO FERNANDEZ FERREIRO

3 (b) If veteran, name war: -

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rosenda Sanchez
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1890

8. AGE: Years	Months	Days	If less than one day
53	10	8 ?	hr. min.

9. Birthplace ? Spain
(Town, county, and state)
10. Usual Occupation Deckhand
11. Industry or business Merchant Marine

FATHER
12. Name Martin Ferreiro
13. Birthplace ? Spain

MOTHER
14. Maiden Name Jesusa Fernandez
15. Birthplace ? Spain

16 (a) Informant Records, U. S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Removal (b) Date thereof 9/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New York
Location N. Y.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

SEP 5 1944 Huntington Williams, MD
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH September 3, 1944, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3, 1944, to Sept. 3, 1944, and that I last saw h im alive on Sept. 3, 1944.

Immediate cause of death	Duration
Diffuse generalized carcinomatoses involving the lungs, hilar & mediastinal mucus lymph nodes, liver, abdominal & retroperitoneal lymph nodes.	Approx 12/1943
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Baltimore, Md. Date signed 9/4/44

MS-54625

M. D. F. 1939-9

G20476 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G20476

CERTIFICATE OF DEATH

61

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Prospect St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 38 yrs. 21 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Ora Bland Sands

(a) Residence: No. 911 Ridgely St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a. If married, widowed, or divorced (or) WIFE of Thomas A. Sands.

6. DATE OF BIRTH (month, day, year) March 16, 1888

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own Home

10. Date deceased last worked at this occupation (month and year) July 1944

11. Total time (years) spent in this occupation 36.

12. BIRTHPLACE (city or town) (State or country) Anne Arundel County

FATHER

13. NAME Richard Henry Watts.

14. BIRTHPLACE (city or town) (State or country) Anne Arundel County.

MOTHER

15. MAIDEN NAME Alice Cranford

16. BIRTHPLACE (city or town) (State or country) Anne Arundel county.

17. INFORMANT Mrs Ruth Ramsey

(Address) 2716 Prospect St

18. BURIAL, CREMATION, OR REMOVAL.

Place Meadow Ridge Dorsey Md Date 9/7, 1944

19. UNDERTAKER William Cook Inc

(Address) 717 St. Paul st

SEP 5 - 1944 Hunting for Williams M.R.

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 3, 1944

22. I HEREBY CERTIFY, That I attended deceased from Aug 29, 1944 to Sept 3, 1944

I last saw her alive on Sept 3, 1944. Death is said to have occurred on the date stated above, at 11:30 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion	7/12/44
Arteriosclerotic Heart Disease	"
with Congestive Failure	
Other contributory causes of importance:	
Diabetes Mellitus	1933

Name of operation ..... Date of .....

What test confirmed diagnosis? E.K.G. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased?

If so, specify .....

(Signed) W. Allen Deckert, M. D.

(Address) 1127 St Paul St

V. S. 3

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G20477

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 Calvert Ave.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3714 Roland Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Nannie F. O'Donnell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband ~~or wife~~ Francis T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 April 1879

8. AGE: Years	Months	Days	If less than one day
65	4	22	hr. min.

9. Birthplace West Virginia (Town, county, and state)
10. Usual Occupation Housef.
11. Industry or business

FATHER
12. Name John J. Brady
13. Birthplace West Va.

MOTHER
14. Maiden Name Florence Britton Hoyt
15. Birthplace West Va.

16 (a) Informant Mrs. Francis J. O'Donnell (Husband)
(b) Address Finfer Apt. #126; 432 E Lovust St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/6/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

SEP 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 September 1944 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 27 Aug., 1944, to 3 Sept. 1944, and that I last saw her alive on 19

Immediate cause of death Cardiovasc. failure

Due to cerebrovascular accident

Due to Hypertensive Cardiovasc. Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas L. Chaffee M. D.
Address Union Mem. Hosp. Date signed 9-3-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20478

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

Registered No. G20478

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. & Calvert
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5s
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 425 E. Lorraine Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles Henry Miller. Jr.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 20 1918

8. AGE: Years	Months	Days	If less than one day
25	11	12	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name Charles A. Miller
13. Birthplace Penna.

MOTHER
14. Maiden Name Hoffa ✓ Hoover
15. Birthplace Md.

16 (a) Informant Pauline Miller
(b) Address 425 E. Lorraine Ave

17 (a) Burial (b) Date thereof 9/5/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Maryland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul st

19 (a) (b) Huntington Williams

SEP 5 150 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2- 1944 at 8 46 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-9 1944 to 9-2 1944 and that I last saw h(im/er) alive on 9-2 1944.

Immediate cause of death	Duration
C-R Failure	
Due to The Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Lill III M. D.
Address Union Memorial Hosp Date signed 9-2-44

G20479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124 N Registered No. G20179

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1841 Orleans St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LAWRENCE FRANIS MEDIARI

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-16-5729

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 13th 1903

8. AGE: Years	Months	Days	If less than one day
41	7	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Manager

11. Industry or business Regan Restaurant

FATHER
12. Name Henry Medtart
13. Birthplace Md.

MOTHER
14. Maiden Name Jennie Lederer
15. Birthplace Md

16 (a) Informant Mrs Jennie Medtart
(b) Address 1804 Orleans St.

17 (a) Burial (b) Date thereof 9/7/44
(Burial, cremation, removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

SEP 5 - 1944 (Date rec'd by Registrar) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4 1944, at 7 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1944 to 9-4 1944, and that I last saw h.[illegible] alive on 9-4 1944.

Immediate cause of death	Duration
Shock and Pulmonary Edema	
Due to Acute Liver Insufficiency	
Due to Laennec's Cirrhosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 9-4-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ely L. Amrich M. D.

Address Sinai Hosp. Date signed 9-4-44

G20480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 R

Registered No. G20480

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2600 Lehmann Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Schwiegerath

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth (Kimpel)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 15, 1883

8. AGE: Years 61 62 | Months - | Days 17 | If less than one day hr. min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Jacob Schwiegerath
13. Birthplace Hungary

MOTHER
14. Maiden Name Unknown
15. Birthplace Hungary

16 (a) Informant Mrs. Elizabeth Schwiegerath
(b) Address 2600 Lehmann St

17 (a) Burial (b) Date thereof Sept 6, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Balto.

18 (a) Funeral director Harry H. Lutz
(b) Address 4101 Edmondson Ave

SEP 5 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1944, at 3:00 PM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH, Carcinoma Colon of abdominal Viscera

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed Sept. 2, 1944

G20481 VORN DICK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

G20481 Registered No.

THIS SPACE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton + Wilkens Ave
(c) Hospital or institution: St. Agnes
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Hosp.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3921 Cranston Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry T. Vorn Dick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	Married

6 (b) Name of husband or wife: Frances K. Schmidt 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1893

8. AGE: Years	Months	Days	If less than one day
51	3	22	hr. min.

9. Birthplace Cincinnati Ohio (Town, county, and state)
10. Usual Occupation Police Officer
11. Industry or business Balto. City

FATHER 12. Name John H. Vorn Dick
13. Birthplace Germany

MOTHER 14. Maiden Name
15. Birthplace Germany

16 (a) Informant Frances K. Vorn Dick
(b) Address 3921 Cranston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.6.44 (month) (day) (year)
(c) Cemetery or crematory Holy Archemon
Location 4500 Belgian Ave.

18 (a) Funeral director Henry H. Meyer
(b) Address 4101 Edmondson Ave.

SEP 5 - 1944 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1944 at 11:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1944 to 9-2 1944 and that I last saw him alive on 9-2 1944

Immediate cause of death: Coronary Occlusion with infarction & myocardial

Due to: Failure

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

Coronary Disease Infarction of autopsy & Myocardial Aneurysm

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. McGrath M.D. M. D.

Address St Agnes Hosp Date signed 9-3-44

G20482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95A

Registered No. G20482

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1238 Carroll St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1238 Carroll St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Mathilda Neumann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F.	W.	Widow

6 (b) Name of husband or wife Late Joseph.
6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1874

8. AGE: Years	Months	Days	If less than one day
70	5	—	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name — Glaser
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.5.44 (month) (day) (year)
(c) Cemetery or crematory St. Paul
Location Violetville Md.

18 (a) Funeral director Harry Hewitt Lee
(b) Address 1101 Edmondson Ave.

SEP 5 - 1944 (Date filed) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1944 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15th 1942 to Sept 1st 1944 and that I last saw her alive on Sept 1st 1944.

Immediate cause of death	Duration
Auricular Fibrillation	2 yrs
Due to Hypertension	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Howard Kaster M. D.
Address 517 Scott St. Date signed 9-2-44

G20483 ~~1944~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54 V

Registered No. G20483

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 Ramsay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 Ramsay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest E. Hepting

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-9596

4. Sex M. | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed late Florence

6 (b) Name of husband or wife Barnes 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1887

8. AGE: Years 57 | Months - | Days 13 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Boiler Shop

11. Industry or business Bartlett Hayward

FATHER 12. Name Ernest K. Hepting
13. Birthplace Virginia

MOTHER 14. Maiden Name Elizabeth —
15. Birthplace Virginia

16 (a) Informant Ernest M. Hepting
(b) Address 1709 Wilkens Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.6.44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Wittke
(b) Address 4101 Edmondson Ave.

19 (a) 1944 (Date rec'd by reg.) (b) Hilton Williams, MR Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944 at 9:a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to 9/2 1944 and that I last saw h. alive on 9/2 1944

Immediate cause of death Carcinoma of Lumbar spine — Duration 6 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 1020 Wilkens Date signed 9/4/44

ave

G20484 BALTIMORE CITY HEALTH DEPARTMENT G20484

CERTIFICATE OF DEATH 5715 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30- 9- 28
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1208 W. Franklin Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME WALTER L. McMAHON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1877

8. AGE: Years 66 | Months 10 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Driver

11. Industry or business

FATHER 12. Name John W. McMahon
13. Birthplace Co. Clore, Ireland

MOTHER 14. Maiden Name Sarah Kennedy
15. Birthplace Baltimore, Maryland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 6 - 44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. City.

18 (a) Funeral director Stewart & Mowen Company
(b) Address 106 W. North Av. (W.T. Wooden-Suc.)

SEP 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4, 1944, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934, to Sept. 4, 1944, and that I last saw him alive on Sept. 4, 1944

Immediate cause of death: Carcinoma of Bladder(inoperable) — Duration: 5 mos.

Due to

Due to

Other Conditions Schizophrenia-Paranoid type — 30 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Manuel P. Vega M. D.
Address 3376 Reisterstown Rd. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46M

G20485 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4216 Penhurst Avenue
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 8
(e) Length of stay in Baltimore (yrs., mos., or days) 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4216 Penhurst Ave.
(If rural give location)
(e) Citizen of foreign country? ? (Yes or No)
If yes, name country ?

3 (a) FULL NAME DR. GUSTAV ASCHAFFENBURG

3 (b) If veteran, name war ----------
3 (c) Social Security Account No. ----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Maria T. Aschaffenburg
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) May 23, 1866

8. AGE: Years	Months	Days	If less than one day
78	3	9	..... hr. ..... min.

9. Birthplace Zweibrucken, Germany
(Town, county, and state)
10. Usual Occupation Medical Doctor - Research at
11. Industry or business Catholic Univ., Wash., D.C.

FATHER
12. Name Louis Aschaffenburg
13. Birthplace Germany

MOTHER
14. Maiden Name Julia Feibes
15. Birthplace Germany

16 (a) Informant Mrs. Maria T. Aschaffenburg (wife)
(b) Address 4216 Penhurst Ave., Balto. City,
17 (a) Burial (b) Date thereof Sept. 5, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Balto. Co., Md.
18 (a) Funeral director Stewart & Mowen Company
(b) Address 108 W. North Av. (W. F. Wooden-Suc.)
19 (a) SEP 5 - 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944, at 11 30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1942 19.. to his death and that I last saw h.. alive on Sept 2 1944
I further state cause of death

	Duration
Generalized Arteriosclerosis	
Old age	
Due to	
Due to	
Other Conditions Acute - Intestinal Spasm (Carcinoma ?)	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: ?
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Kurt Levy
Address 1301 Jordan Pl. Date signed 9-3-44 M. D.

Kurt Levy, M.D.

G20486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 ✓

G20486 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please in case write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore City
(b) Street address 1410 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1410 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Riley Kebble
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Bellcast Kebble
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 7th 1902

8. AGE: Years	Months	Days	If less than one day
37	1	27	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Edward L. Riley, Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Daisy A. Hill
15. Birthplace Baltimore Md

16 (a) Informant Daisy A. Riley
(b) Address 1410 Harlem Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 7-7-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk
Location Baltimore Md

18 (a) Funeral director Archibald G. Haddaway
(b) Address 210 N. Bulford St. Balto Md

19 (a) (b) Filed SEP 5 1944 Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944, to Sept 3 1944, and that I last saw h.. alive on Sept 1 1944

Immediate cause of death Carcinoma of Rectum — Duration any 1943

Due to

Due to Liver metastases — Duration 1943

Other Conditions General Complications. — Duration 15 yrs

(Include pregnancy within 3 months of death)

Date of operation June 17, 1943

Major findings of operation: As above mentioned

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ~
(b) Date of occurrence ~ at ~ M
(c) Where did injury occur? ~ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ~ (Specify type of place) While at work? ~
(e) Means of injury ~

23. Signature Bernard S. Shenck M.D.
Address 2379 Arunah Ave Date signed 9/4/44

G20187

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20187 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1083 Elliott Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1083 Elliott Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie May Kilbourn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Robert S
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 1882

8. AGE: Years	Months	Days	If less than one day
62	6	28	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Marshall M. Hahn
FATHER 13. Birthplace Md

MOTHER 14. Maiden Name Eliza J. Gaylord
MOTHER 15. Birthplace Md

16 (a) Informant Mrs Violet G. Smith
(b) Address 1087 Elliott Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director L. J. Rusk
(b) Address 5305 Harford Rd

(a) SEP 5 1944 (b) Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1944 at 4P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944 to 9/2 1944 and that I last saw her alive on 9/2 1944.

Immediate cause of death Uremia
sclerosis Cardio Vascular disease — Duration 1 hr

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller
Address 2036 Wilkens ave Date signed 9/5/44

Washington Williams, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G20188 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL or V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 EAST 35TH ST
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M. FICK

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife JOSEPH G. FICK
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-15-1889

8. AGE: Years	Months	Days	If less than one day
55	5	21	hr. min.

9. Birthplace BALTIMORE, BALTIMORE, MD
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOHN MARLEY
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name ELIZABETH LOESSP
15. Birthplace MARYLAND

16 (a) Informant MRS. JOHN J. MILLER
(b) Address 1513 E. 35TH ST BALTO.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. ROCK
(b) Address 5395 Harford Rd

19 SEP 5 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT 4, 1944, at 9:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-15 1944 to 9-4 1944, and that I last saw her alive on 9-4 1944

Immediate cause of death	Duration
CARDIO RESPIRATORY FAILURE	1 hr.
Due to PULMONARY EMBOLUS	
Due to	
Other Conditions FRACTURE HUMERUS LEFT	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence August 15, 1944 M
(c) Where did injury occur? 1515 E. 35th St Balto. Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At Home While at work? No.
(Specify type of place)
(e) Means of injury Fell down stairs
23. Signature Stephen J. Sulton M.D.
Address Union Memorial Hosp. Date signed 9-7-44

For Dr Robt Jas Graham, by Howard J. Masters, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

18ca G20489

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 527 Beaumont Ave.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Francis Huber, Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 11 1943

8. AGE: Years	Months	Days	If less than one day
1yr.	one	21	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Joseph F Huber Sr
13. Birthplace Balto Md

MOTHER
14. Maiden Name Dolores Lynch
15. Birthplace Balto Md

16 (a) Informant Mrs Dolores Lynch
(b) Address 527 Beaumont Ave

17 (a) Burial (b) Date thereof 9-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location

18 (a) Funeral director L.J. Ruck
(b) Address 1305 Harford Rd

19 (a) SEP 5 1944 (b) Huntington Wilson Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2-44 19 , at 3:45p M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2-44 3:15p.m. to 9-2-44 3:45pm, and that I last saw him alive on 9-2-44 19

Immediate cause of death Fractured Skull (Basal) — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-2-44 at 3:00 p.m.
(c) Where did injury occur? Balto., Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work?
(Specify type of place)
(e) Means of injury Fell down cellar steps

23. Signature Frank L. Vanni, M. D.
Address St. Joseph's Hosp. Date signed 9-2-44

Approved by Howard J. Mercer M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G20490 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 724 E. 20th St.
(c) Hospital or institution: 9 [illegible]
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 E 20th St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Jeu Gable

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 220-05-5063 A

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Gable

6 (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, y) Jan 8 - 1861

8. AGE: Years 83 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace Warwick Pa -
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name Conrad Gable

13. Birthplace Germany

MOTHER 14. Maiden Name Barbara Seiler

15. Birthplace Germany

16 (a) Informant Mrs. Anna Gable

(b) Address 724 E 20th St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 6/44 (month) (day) (year)

(c) Cemetery or crematory DRUID RIDGE

Location PIKESVILLE MD.

18 (a) Funeral director Lilly and Geiler INC.

(b) Address 403 S. WOLFE ST.

19 SEP 5 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4- 1944 at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 1943 to Sept 4 1944
and that I last saw h[illegible] alive on Sept 3 1944

Immediate cause of death: Cardio-renal - Sclerosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Jany 1944

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. Gardner

Address 1517 E Northern Date signed 9/7/44

Bulk 13 71

G20491

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20491
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4421 Norwood Rd.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J Russell

3 (b) If veteran, name war: no
3 (c) Social Security Account No.:

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: James S. Russell
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) October 20-1898

8. AGE: Years 45 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace Md. Snow Hill, Md.
(Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business Home

FATHER
12. Name James A Truitt
13. Birthplace Md. Snow Hill, Md.

MOTHER
14. Maiden Name Lydia M Foster
15. Birthplace Md. Girdletree, Md.

16 (a) Informant James S. Russell
(b) Address 4421 Norwood Rd city

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept-6-1944 (month) (day) (year)
(c) Cemetery Presbyterian
Location Snow Hill, Md.

18 (a) Funeral director Wm. J. Tickner & Sons.
(b) Address North & Penna Aves. Baltimore, Md.

19 (a) SEP 5 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3/ 1944, at 6 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/17/44 19 to 9/3 1944, and that I last saw h. alive on 9/3 1944.

Immediate cause of death: Resp. Failure — Duration:
Due to: Disseminated multiple Sclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: none
Major findings of operation:
of autopsy: Lesions in Brain Stem

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Ratliff, Jr. M.D.
Address University Hosp Date signed 9/3/44

G20192

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 V

Registered No. G20192

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 10 E. Eager St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME OLA B. De CORSE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Claude E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1883

8. AGE: Years	Months	Days	If less than one day
61	1	23	hr. min.

9. Birthplace Thomasville, N. C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles T. Beasley
13. Birthplace N. C.

MOTHER
14. Maiden Name Kate Hannah
15. Birthplace N. C.

16 (a) Informant Miss Aileen De Corse
(b) Address 10 E. Eager St.

17 (a) Burial (b) Date thereof 9-6-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 5 - 1944 for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1944, at 9:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 31 1944 to Sept 3 1944, and that I last saw h alive on Sept 2 1944

Immediate cause of death: Acute dilatation Heart — Duration 12 day

Due to Hypertension — about 1 mo

Due to Advanced arteriosclerosis

Other Conditions: Cystic Leucorrhea + Pain — duration about 1 mo.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter Dilkett M. D.
Address 2220 Harrison Blvd Date signed Sept. 5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The respect age is especially important. Physicians: please write the causes of death clearly and legibly.

2643 30493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20493 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: Johns Hopkins Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 Brunt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estella Parran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	black	married

6 (b) Name of husband or wife William Parran
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) 5-13-96

8. AGE: Years	Months	Days	If less than one day
48 47	3	19	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Harry Briscoe
13. Birthplace Md

MOTHER
14. Maiden Name Charlotte
15. Birthplace

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Hoffman & Hemsley
(b) Address 578 W. Biddle St.

SEP 5 1944 (Date received by Registrar) (b) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944 at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 30 1943, to Sept. 2 1944, and that I last saw h.. alive on Sept. 2 1944

Immediate cause of death	Duration
Cardiac failure	
Due to Hypertensive CV renal disease	> 6 yrs.
Due to	
Other Conditions Diabetes mellitus Cerebral hemorrhage	7 2 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Burmingham M. D.
Address JHH Date signed 9-2

G20494 ✓ G20494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3533 Keswick Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) [redacted]
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3533 Keswick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Hulse

3 (b) If veteran, name war None

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elsie Carlock Hulse

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 18-1877

8. AGE: Years 67 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Retired

MOTHER / FATHER

12. Name James Hulse

13. Birthplace Unknown

14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Mrs. Elsie C. Hulse

(b) Address 3533 Keswick Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6-44 (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location Freeland Md

18 (a) Funeral director Rev. L. Beyer Jr

(b) Address 1512 Hollins St

19 (a) SEP 5 - 1944 (Date received by registrar) Huntington Williams, M.D. (signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1944 at 5.50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh B. McNally M.D.

Address Medical Investigator

VS 180

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G20495 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1812 E. Madison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1812 E. Madison St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Flora ~~Chatham~~ Height

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife George Height

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 30, 1900

8. AGE: Years 43 | Months 8 | Days 5 | If less than one day hr. min.

9. Birthplace Vienna Md. (Town, county, and state)

10. Usual Occupation School teacher

11. Industry or business Education

FATHER
12. Name Enoch Wilson
13. Birthplace Vienna Md

MOTHER
14. Maiden Name Rachel Stanley
15. Birthplace Salem Md.

16 (a) Informant Sister - Mary Conchious
(b) Address 1999 Swedesboro Ave Gloucester N.J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 (month) 7 (day) 44 (year)
(c) Cemetery or crematory Druid Ridge
Location Dargan Rd

18 (a) Funeral director Samuel W. Chase & Son
(b) Address 638 N. Gilmor St.

19 SEP 5 1944 (b) Registrar
Registered by
VS 188 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4th 1944, at 5:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21st 1944, to Sept 4th 1944, and that I last saw h-r alive on Sept. 4th 1944

Immediate cause of death Cerebral Embolis — Duration

Due to Auricular thrombosis

Due to Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ronald B. Hightower Jr. M. D.
Address 2129 Druid Hill ave Balt-17 md. Date signed 9/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

057316
G20496

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20496
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Edgemere Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Horne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-31-44

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Howard Horne
13. Birthplace N.Y.

MOTHER
14. Maiden Name Theresa Petrosa
15. Birthplace W. Va.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/4/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John S Connelly
(b) Address 419 Eastern Ave. Edgewood

19 (a) (b)
(Date received by local registrar) Registrar

SEP 5 - 1944
VS/150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1944; at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 3 1944, and that I last saw h alive on Sept 3 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Prematurity Severe.	
Due to Hemorrhagic Disease of the newborn	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad
Address Johns Hopkins Hosp. Date signed 9.3.44 M. D.

G20497

BALTIMORE CITY HEALTH DEPARTMENT 94a

CERTIFICATE OF DEATH

G20497 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Balto City Hospital-D.O.A

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Essex Md
(If outside city or town limits, write RURAL and give town)
(a) Street No. Back River Neck
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Heise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Sophia Heise (Spouse)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1887

8. AGE: Years	Months	Days	If less than one day
57	7	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Fisherman
11. Industry or business —

FATHER
12. Name Emil C. Heise
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary A Wilson
15. Birthplace Balto. Md.

16 (a) Informant Mrs Sophia Heise wife
(b) Address Harrison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director John H Connelly
(b) Address 410 Eastern Ave. Edgewood

19 (a) (Date received by registrar) (b) Registrar

SEP 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 1944, at 2:20 M

21. I certify that I took charge of the remains described above, held an Inquiry - Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury

23. Signature Chester F. Fulmer M.D.
Medical Examiner.
Date signed 9/7/44

G20198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20198 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 438 S.Bonsal St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 438 S.Bonsal St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry S.Murdock

3 (b) If veteran, name war ---

3 (c) Social Security Account No. 212-09-8160

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Anna M.Murdock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31,1894

8. AGE: Years	Months	Days	If less than one day
50	1	2	hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name James E.Murdock
13. Birthplace Balto.Md.

MOTHER
14. Maiden Name Dorothea Koch
15. Birthplace Germany

16 (a) Informant Mrs.Anna M.Murdock
(b) Address 438 S.Bonsal St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.6/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto.Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (Date rec'd) SEP 5 1944 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.2nd.44 19 , at 10 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1941, to Sept 2 1944, and that I last saw h alive on Sept 1 1944.

Immediate cause of death	Duration
Diabetes Mellitus	1-2-41
Myocardial Degeneration	8-12-43
Due to Myocardial Failure	9-29-44
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ear Scheinuk M. D.
Address 842 S. Eaton St. Date signed 9-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G20499 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 228 N.Milton Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 228 N.Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary S.Graf

3 (b) If veteran, name war	3 (c) Social Security Account No.
---	---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June3,1872

8. AGE: Years	Months	Days	If less than one day
72	3 2	29	hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name John Graf
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Cramer
15. Birthplace Germany

16 (a) Informant Miss Catherine Graf
(b) Address 228 N.Milton Ave.

17 (a) Burial (b) Date thereof Sept.6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto.Md.

18 (a) Funeral director Philip Keuper & Sons
(b) Address 2024 Orleans St.

19 (a) (Date received by registrar) (b) Registrar

SEP 5 - 1944

VS 15P

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.2/44 19 , at 7 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943 to Sept 2. 1944
and that I last saw h[illegible] alive on Sept 2 1944

Immediate cause of death Chronic Nephritis
Secondary Uraemia
Due to Arteriosclerosis
Hypertension
Due to Cardio-Vascular
disease

Duration
?
?
?
?

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(d) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Kluines M. D.
Address 2223 E. Monument Date signed 9/4/44

Huntington Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20500 (Registered No.)

G20500

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town, write rural district)
(d) Street No. Caroline & Oliver Sts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma Needer (Emma Needer)

3 (b) If veteran, name war —
3 (c) Social Security Account No. ---

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Conrad Needer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1886

8. AGE: Years	Months	Days	If less than one day
57	11	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name William Dashner
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Elizabeth Anschutz
15. Birthplace Germany

16 (a) Informant Mr. Conrad Needer
(b) Address 2430 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto. Md.

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St.

19 (a) (b) (Signature of registrar) Registrar

SEP 5 - 1944
VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1944 at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944 to 9/2 1944 and that I last saw h alive on 1944

Immediate cause of death: Cerebral Embolism — Duration

Due to Hypertension & Decompensation

Due to

Other conditions Diabetes Mellitus
Gangrene left foot
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lucien Jaworski, M.D.
Address St. Joseph Hospital Filed 9/2

G20501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20501 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1355 N. Calhoun St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1355 Calhoun
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ellen Sarah Young

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Colored	Widowed

6 (b) Name of husband or wife William Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name —
13. Birthplace Md

MOTHER
14. Maiden Name Hodges
15. Birthplace Md

16 (a) Informant Mary D. Jones
(b) Address 1355 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-44 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Md

18 (a) Funeral director George D. Nelson
(b) Address 1303 Presstman St

19 (a) SEP 5 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1- 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944, to Sept 1- 1944; and that I last saw him alive on Aug 31- 1944

Immediate cause of death Uremia Cause

Duration
1 day

Due to Chron Nephritis + Scoliosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.R. Hopkins M.D.
Address 1135 Eutaw Date signed 9/6/44

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G20502 Registered No.

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1027 N. Stricker St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1027 N. Stricker St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Irene Ridout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fem.

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1923

8. AGE: Years 21 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Md

MOTHER
14. Maiden Name Lillian Ridout
15. Birthplace Md.

16 (a) Informant Lillian Ridout
(b) Address 1027 N. Stricker St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion Cem
Location Md

18 (a) Funeral director Geo. S. Nelson
(b) Address 1303 Pennsylvania Ave Huntington Williams, Registrar

19 (a) SEP 5 1944 (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1944 at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29- 1944 to 9-3- 1944 and that I last saw h[illegible] alive on 9-3- 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration 6 Mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page
Address 1516 N. Mount St. Date signed 9-5-44 (M.D.)

G20503
AB-88723

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20503
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-5days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1350 Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Scriber

3 (b) If veteran, name war —
3 (c) Social Security Account No. 214-03-4976

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Kate
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-48? 1896

8. AGE: Years 48? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William Scriber
13. Birthplace Md.

MOTHER
14. Maiden Name Sophie ?
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt Peters Cem
Location md

18 (a) Funeral director George H. Wilson
(b) Address 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) SEP 5 1944 (b) Registrar Huntington Williams, M.D.
VS IIe

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2-1944, at 10.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 27- 1944, to Sept-2- 1944, and that I last saw him alive on Sept-2 1944.

	Duration
Immediate cause of death: Bronchopneumonia	3+days
Due to: Left hemiplegia	12 mos
Due to: Cerebral Hemorrhage due to arteriosclerosis	?
Other Conditions: Gen. arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Kenneth Smith
Address Balt. City Hosp. Date signed 9/3/44 M. D.

G20504

BALTIMORE CITY HEALTH DEPARTMENT X G20504

CERTIFICATE OF DEATH 1256

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette st.
(c) Hospital or institution: Bon Secours Hospital.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Harwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. Near Washington Blvd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Smith

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1944

8. AGE: Years: 25 days | Months: aug. | Days: 10 | If less than one day: 25 hr. min.

9. Birthplace: Balt. Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Mr. L. E. Smith
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Ruth Dudrow
15. Birthplace: Harwood, Md.

16 (a) Informant: Mr. Louis Smith Son
(b) Address: Harwood Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 5, 1944 (month) (day) (year)
(c) Cemetery or crematory: Western Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Easton Sons
(b) Address: Ellicott City, Md.

19 SEP 5 - 1944 (Date rec'd by Registrar) (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1944 at 9:35 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/10 1944 to 9/4 1944 and that I last saw him alive on 9/4 1944

Immediate cause of death	Duration
Multiple abscesses of liver	10 days
Due to Probable Staphylococcus septicemia	20 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Multiple Abscesses Viscera

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Raymond Royer M. D.
Address: Bon Secours Hosp. Date signed 9/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20505 G20505

BALTIMORE CITY HEALTH DEPARTMENT

AB-72258 CERTIFICATE OF DEATH 13 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs-3mos. 26days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 732 West Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Talley Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James Talley (D)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9-1912

8. AGE: Years	Months	Days	If less than one day
31	10	21	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name William Caroll
13. Birthplace ?

MOTHER
14. Maiden Name Emma Holl
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

19 (a) Filed SEP 5 1944 (b) Remington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30- 1944, at 3AM M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-4-1942 to 8-30- 1944, and that I last saw her alive on 8-30- 1944

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Phillips M. D.
Address Bolt Ctr, Md Date signed 8-30-

G20506

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1192

Registered No. G20506

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 702 Edmondson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Geraldine Howard.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birthdate of deceased (mo., day, yr.) 1-2-44

8. AGE: Years	Months	Days	If less than one day
	2	2	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Cleveland Boyd
13. Birthplace Hampton Va

MOTHER
14. Maiden Name Catherine Howard
15. Birthplace Lexington - N.C.

16 (a) Informant Mrs. Catherine Howard
(b) Address 702 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5, 19 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Mortuary

VS 150 SEP 5 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2 19 44, at 2 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 19 44 to Sept. 2 19 44, and that I last saw h[illegible] alive on Sept 2 19 44.

Immediate cause of death Acute Gastro enteritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. J. Mansfield M. D.
Address Provident Hospital Date signed 9/5/44

G20507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131

G20507 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Stret.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 N. Castle St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Minus Yehle

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-10-2543

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1888

8. AGE: Years	Months	Days	If less than one day
56	0	5	hr. min.

9. Birthplace Phila. Pa. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Crown Cork & Seal

FATHER
12. Name Frederick C. Yehle
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Powers
15. Birthplace Ireland

16 (a) Informant Theodore Yehle
(b) Address 1707 N. Castle Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc
(b) Address North Avenue & Broadway

19 (a) SEP 5 - 1944 (Date received by registrar) (b) Eugene Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1944 to 9-2 1944 and that I last saw him alive on 9-2 1944.

Immediate cause of death: Uraemic myocarditis. Cardiac hypertrophy.

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight O. MacDonald M. D.
Address 1213 Light St Date signed 9-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20508

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G20508

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 Chilton Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 wk
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundl
(c) City or town Pasadena, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. Mt. Road & Outing Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN LUTZ

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Lutz
6 (c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Mar. 24, 1872

8. AGE: Years: 72 | Months: 5 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Fireman. Ret. 14 yrs
11. Industry or business: Balto. City

FATHER
12. Name: Martin Lutz
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Vogler
15. Birthplace: Germany

16 (a) Informant: John Lutz
(b) Address: 4403 Walther Avenue- 14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-5-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc
(b) Address: North Avenue & Broadway
Huntingdon Baltimore, Md

19 (a) SEP 5 1944 (b) (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 19 44, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 19 44 to Sept 1 19 44, and that I last saw h-- alive on Sept 1 19 44.

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 day
Due to: Hypertension — Duration: ?
Due to: Arterio - Sclerosis — Duration:
Other Conditions: Aug 16/44 — Duration:
(Include pregnancy within three months of death)
Date of operation: Aug 16/44
Major findings of operation:
Non-malignant
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature: C N Meyer Jr
Address: 1500 E 33rd St Date signed 9/2/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 117 N

G20509 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmont
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3822 Hudson St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George David Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife IRENE J. LAW

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8 1886

8. AGE: Years	Months	Days	If less than one day
58	4	23	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Foreman

11. Industry or business

FATHER
12. Name David Evans
13. Birthplace Wales

MOTHER
14. Maiden Name Hannah Williams
15. Birthplace Baltimore, Md.

16 (a) Informant Paul Evans
(b) Address 3822 Hudson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co.

18 (a) Funeral director Blaine & Hoffman
(b) Address 1639 E. Broadway

19 (a) SEP 5 - 1944 (Date received by registrar)

Huntingtown Williamsport Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1944 at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11-1944 to 9-1-1944 and that I last saw him alive on 9-1-1944

Immediate cause of death	Duration
Toxemia	
Due to Subdiaphragmatic abscess + empyema, r.t.	5 weeks
Due to Perforated gastric ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8-18-44

Major findings of operation: Incision + drainage of subdiaphragmatic abscess

of autopsy: Perforated ulcer + empyema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harrison Latta M. D.

Address Church Home & Hospital Date signed 9-1-44

G20510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124b

G20510 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2003 Ridgehill Ave
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 43 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(c) Street No. 2003 Ridgehill Ave (If rural give location)
(d) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME William F. Scrivenor

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Hettie Gertrude
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) June 22 - 1872

8. AGE: Years	Months	Days	If less than one day
72	2	12	hr. min.

9. Birthplace Carroll Co (Town, county, and state)
10. Usual Occupation Motorman
11. Industry or business United Railway

FATHER
12. Name John Scrivenor
13. Birthplace Carroll Co

MOTHER
14. Maiden Name Mary Bidner
15. Birthplace Carroll Co

16 (a) Informant Mrs Ryan
(b) Address 1529 Ind Keany Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 6-44 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave

18 (a) Funeral director Walter Brooks Bradley
(b) Address 1122 N Monroe Ave

19 (a) SEP 5 - 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1944, at 11 15 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/2 1944 to 9/3 1944, and that I last saw deceased alive on 9/2 1944.

Immediate cause of death: Cardiac failure & Pulmonary edema — Duration

Due to: Carcinoma of liver

Due to:

Other conditions: Hearing defend Anaroxia.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Amelia Scrivenor
Address St Joseph Hospital Signed 9/3/44 M.D.

G20511 Bernadzikowski

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √46d

Registered No. G20511

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Caroline St
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 S. Pattenson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Henry Bernadzikowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Oct 1 1870

8. AGE: Years 73 | Months 74 | Days 11 | If less than one day hr. min. 1

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation B. O. R. R. Co.

11. Industry or business

FATHER 12. Name Martin Bernadzikowski

13. Birthplace Poland

MOTHER 14. Maiden Name Mikrayn

15. Birthplace Poland

16 (a) Informant Mrs Mary Bernadzikowski

(b) Address 508 S. Pattenson Park Ave

17 (a) Burial (b) Date thereof Sept 6/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary Cem

Location Baltimore County

18 (a) Funeral director John M. Webeck

(b) Address 401 S. Chester Street

SEP 5 - 1944
(Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2 1944 at 12 20 M

21. I certify that death occurred on the date above stated, that I attended deceased from 8/22 1944 to 9/2 1944, and that I last saw h[illegible] alive on 9/2 1944

Immediate cause of death: Cardiac Failure — Duration

Due to

Due to

Other Conditions Carcinoma of Rectum
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: Ca of Rectum & Sigmoid

of autopsy:

PHYSICIAN

Underline the cause to which [illegible] be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen Jasionski

Address St Joseph Hospital Date signed 9/2/44

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

G20512 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Levindale Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Belle Sugar

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Samuel J. Sugar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis L. Sacks
13. Birthplace Russia

MOTHER
14. Maiden Name Hinda
15. Birthplace Russia

16 (a) Informant Aaron Jesse Sugar
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 5/44 (month) (day) (year)
(c) Cemetery or crematory Reform Hebrew Burying Ground
Location Bowley Lane

18 (a) Funeral director H. Sherman & Bros.
(b) Address 1124-26 W. North ave

19 (a) SEP 5 - 1944 (Date rec'd by registrar)

Huntington Williams, M.H.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1944 at 4:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to 9-4 1944 and that I last saw h[er] alive on 9-4 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Cystopyelitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel for Dr. H. Sherman M. D.
Address Levindale Date signed 9-4-44

G20513

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 944

Registered No. G20513

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State 2nd (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5078 Bond Street (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Thomas Waisk

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-0046

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name unknown
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Employer Black
(b) Address 32 Pelham Ave Essex Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 4 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location Lemon Hill Rd.

18 (a) Funeral director James J Bundgaard
(b) Address 1807 Edison Hwy Rd

19 (a) SEP 5 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31, 1944 at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at ..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work?.....
(d) Means of injury.....

23. Signature H. J. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 9-1-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20514

AB-89544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30C G20514

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days

(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 720 Wilmer Ct.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Estelle Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16- 1885

8. AGE: Years 59 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

13. Birthplace ?

MOTHER 14. Maiden Name Catherine Gaines

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals-Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-7-44

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.

Location Baltimore Md.

18 (a) Funeral director William A. Jackson

(b) Address 916 Penna. Ave.

19 (a) SEP 5 1944 Registrar Huntington Williams, M.D.

(Date received)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-3- 1944, at 10.35p M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-27- 1944 to 9-3 1944, and that I last saw h er alive on 9-3- 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2da +
Due to: Meningovascular Syphilis	?
Due to:	
Other Conditions: Luetic aortitis	?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature H. Kenneth Shirk M.D.

Address Balt. City Hosp. Date signed 9/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 131 N G20515 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) 4d

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Carroll Frederick
(c) City or town Westminster
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Augemer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M ?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
33	10	4	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John Augemer
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Krunek
15. Birthplace Germany

16 (a) Informant Hosp.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3/44 (month) (day) (year)
(c) Cemetery or crematory St. Dominic Location Carroll County Md

18 (a) Funeral director Jacob Bair & Sons.
(b) Address Manchester, Md.

19 (a) (Signature of registrar) (b) Registrar

SEP 5 - 1944

VS 116

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/44 19 , at 6:35 P M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 1 1944, to Sept 4 1944, and that I last saw him alive on Sept 4 1944

Immediate cause of death	Duration
Cardiac failure	
Due to Malignant hypertension	
Due to Nephrosclerosis	
Other Conditions Uremia, acidosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. L. Gaynther
Address Mercy Hosp Date signed 9/7/44

331085 G20516 BALTIMORE CITY HEALTH DEPARTMENT G20516

CERTIFICATE OF DEATH 30d

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 N. Mechanic St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie D Washington (Geneva)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Frank Washington
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3-2-98
8. AGE: Years 46 | Months 5 | Days 29 | If less than one day hr. min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name William Smith
13. Birthplace (Md)
MOTHER 14. Maiden Name Jennie Jenkins
15. Birthplace (Md)
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof Sep 7 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director G H Ahrens
(b) Address 9 E Lanvale
(a) Date received SEP 5 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1, 1944 at 5:30 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 1 1944 and that I last saw her alive on Sept 1 1944

Immediate cause of death Cardiac failure
Due to Syphilitic aortitis & aortic regurgitation
Due to ? myocardial infarct
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Dec'd

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. Genecin M. D.
Address J. Hopkins Hospital Date signed 9-1-44

G20517

459729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G20517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woundale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 222 Oakwood Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Acors

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-24-44

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Earl Acors
13. Birthplace Va.

MOTHER 14. Maiden Name Bennies Battalla
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 5 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 5 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 29 1944 at 4 36 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1944 to Aug 29 1944 and that I last saw h alive on Aug 29 1944

Immediate cause of death: cerebral hemorrhage — Duration: 5 days

Due to: prematurity

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp Date signed 8-29-44

VS 150

2129

G20518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V161a

Registered No. G20518

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2620 Flora Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Hollman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Black

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 25, 1944

8. AGE: Years | Months | Days | If less than one day: 14 hr. 40 min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER
12. Name: Bill Hollman
13. Birthplace: Georgia

MOTHER
14. Maiden Name: Jane Squirrel
15. Birthplace: Maryland

16 (a) Informant: Hospital Records
(b) Address: Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS MEDICAL SCHOOL SEP 5 1944

18 (a) Funeral director: Commissioner of Health
(b) Address

SEP 5 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1944, at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 25 19 44 to Aug. 25 19 44 and that I last saw him alive on Aug. 25 19 44

Immediate cause of death: Intrauterine Asphyxia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip P. Steptoe, Jr. M. D.

Address Johns Hopkins Hospital Date signed 8-29

2130

G20519

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G20519
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1147 Calhoun Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Oscar Terry

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Frances Terry
6 (c) If alive, give age 19 years

7. Birth date of deceased (mo., day, yr.) 10 / 3 / 1922

8. AGE: Years	Months	Days	If less than one day
21	10	3	hr. min.

9. Birthplace Charlotte Virginia
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Yoge

FATHER
12. Name Oscar Terry
13. Birthplace Charlotte Virginia

MOTHER
14. Maiden Name Fenie Waters
15. Birthplace Charlotte Virginia

16 (a) Informant
(b) Address 1037 N. Mount St

17 (a) Wednesday (b) Date thereof Sept 6 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Annapolis Avenue
18 (a) Funeral director Hugh A. Lively
(b) Address 661 N. Carrie St

19 (a) SEP 5 1944
(Date rec'd by registrar)
Huntington Williams
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-3- 1944, at 1.10 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Stab wound of Heart

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-3-44 at 12.30 A M.
(b) Where did injury occur? 1147 Calhoun St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Sharp instrument
23. Signature Howard J. Claussen M.D.
Medical Examiner.
Date signed 9-3-44

G20520

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G20520

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) ~~Since 8/7/44~~ 30 14
Since 8/7/44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town ~~XXXXXX~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Mosher Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD MARSHALL RUSSELL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col.	Married

6 (b) Name of husband or wife Minnie (Lee)
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 27, 1893

8. AGE: Years	Months	Days	If less than one day
51	3	7	hr. min.

9. Birthplace Prince Frederick, Md.
(Town, county, and state)
10. Usual Occupation Cook - 6 Yrs. ago
11. Industry or business -

FATHER
12. Name Joseph Russell
13. Birthplace Prince Frederick, Md.

MOTHER
14. Maiden Name Charlotte White
15. Birthplace Prince Frederick, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof 9 7 44
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery or crematory U.S. Balto National
Location Balto.

18 (a) Funeral director A. Lee Oder
(b) Address 4444 York Rd.

19 (a) (Date rec'd by Local Reg.) (b) Huntington Hill Registrar

Sept 5

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Sept. 3, 1944, at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 7, 1944 to Sept. 3, 1944, and that I last saw him alive on Sept. 3, 1944.

Immediate cause of death Marked nephro-sclerotic kidneys; Marked cardiac hypertrophy with coronary sclerosis. — Duration: Several yrs. Was also in hosp. 1941

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank Ackerman M. D.
Address Baltimore, Md. Date signed 9/4/44

Va-14537

G20521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G20521 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 234 N. Port St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Sussan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-1-43

8. AGE: Years | Months: 10 | Days: 3 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Charles Sussan

13. Birthplace Md.

MOTHER 14. Maiden Name Mildred Mosley

15. Birthplace Md.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 6 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Balto. Liberty Rd.

18 (a) Funeral director John J. Miller

(b) Address 934 Lafayette St.

SEP 5 1944

19 (a) (Date rec'd by registrar) Clifton T. Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1944 at 12:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1944 to Sept 4 1944 and that I last saw her alive on Sept 4 1944

Immediate cause of death: respiratory failure — Duration: 24 hours

Due to: acidosis — Duration: 24 hours

Due to: pneumonia, bronchial — Duration: 1 week

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Leonard Joel Koenig M. D.

Address Johns Hopkins Hosp. Date signed 9-4-44

G20522

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20522 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3050 Mayfield Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2315 E. Madison Street
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie B. W. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/28/1875

8. AGE: Years	Months	Days	If less than one day
69	3	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John E. Smith
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Margaret Schwartz (Niece)
(b) Address 3050 Mayfield Avenue

17 (a) Burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or CREMATORY Oakland
Location

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) SEP 5 - 1944 (b)
(Date rec'd by registrar) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1944, at 12-30 A M

21. I certify that death occurred on the date above stated: that I attended deceased from Aug. 20 1944 to Sept. 5 1944, and that I last saw her alive on Sept 2 1944

Immediate cause of death Coronary Thrombosis

Duration
2 weeks

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Pokorny M. D.
Address 2200 E Madison Date signed 9/5/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20523 Charles Putens

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20523 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out the full name of each place. Do not use initials or figures, except in dates. Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution: Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Valley & Eager Streets
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charle Putens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Florence Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/1877

8. AGE: Years 67 | Months 6 7 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Louis Putens
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Lewis
15. Birthplace Germany

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Baltimore Md

17 (a) Burial (b) Date thereof 9/7/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

Sep 5 1944 (b) Huntington Williams, Mgr
(Date) (Signature of local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-3 1944 at 8-15A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Sept 1944, and that I last saw him alive on 19

Immediate cause of death	Duration
Edema of Lungs	1 Day
Due to Chronic Myocarditis	3 Yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E Gill Hall M. D.
Address 1631 E North Ave Date signed Sept 7-44

G20524 G20524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grover Duke

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-5[illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Anna L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1885

8. AGE: Years	Months	Days	If less than one day
59	6	26	hr. min.

9. Birthplace Hopkinsville Ky. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Bethlehem Fairfield

FATHER:
12. Name John T. Duke
13. Birthplace Ky.

MOTHER:
14. Maiden Name Bella Overton
15. Birthplace Ky.

16 (a) Informant Mrs. Anna L. Duke
(b) Address 705 N. Fulton Ave.

17 (a) Removal (b) Date thereof 9-6-44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Hopkinsville, Ky.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Balto. Md.

SEP 5 - 1944 (Date rec'd by registrar) (Signature of Registrar) for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944, at 9:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 4 1944, and that I last saw him alive on Sept 4 1944.

Immediate cause of death: Hepatic insufficiency — Duration

Due to metastatic carcinoma to the liver

Due to carcinoma of the head of the pancreas

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: see above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Hallon
Address Sinai Hosp. Date signed 9/5/44 M. D.

G20525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20525 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution: St. Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1822 W Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frederick Menkel (Frederick William Menkel)

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie S.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19 - 1881

8. AGE: Years 63 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Junior Clerk

11. Industry or business City Water Dept.

FATHER
12. Name George Phillip Menkel
13. Birthplace --

MOTHER
14. Maiden Name Emma --
15. Birthplace --

16 (a) Informant Mrs. Annie S. Menkel
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 1944 (Date rec'd by registrar) (b) Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1944, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1944 to 9/4 1944 and that I last saw h.i.m. alive on 9/4 1944

Immediate cause of death: Heart failure — Duration:
Due to Coronary Thrombosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] Barnes M.D.
Address 21 E Eager St Balto Date signed 9/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20526
AB-55307

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20526
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs- 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 S. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Kuzma

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Annie (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1866

8. AGE: Years	Months	Days	If less than one day
77	9	16	hr. min.

9. Birthplace Hungary
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER: 12. Name Michael Kuzma
13. Birthplace Hungary

MOTHER: 14. Maiden Name Susie ?
15. Birthplace Hungary

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Krumpleroch & Son
(b) Address 400 N. Chester Street

SEP 6-1944
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4- 1944, at 12.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-4- 1944, to 9-4- 1944, and that I last saw him alive on 9-4 1944.

Immediate cause of death: Pneumonia — Duration 3 da.
Due to Cerebral thrombosis? hemorrhage? — 1 wk
Due to Cerebral arteriosclerosis — ?
Other Conditions Hypertensive Cardiovascular disease — ?
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: and foot

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Kenneth Smith
Address Balt. City Hosp. Date signed 9/4/44
M. D.

G20527

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G20527
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Garland & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore 21
(If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Myrtle Ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Mattie Gregory

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife David Gregory
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 15, 1888

8. AGE: Years 55 | Months 10 | Days 17 | If less than one day — hr. — min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None
11. Industry or business —

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Emily Smith
15. Birthplace Virginia

16 (a) Informant Mary M. Shee
(b) Address 414 Myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy J. Wilson
(b) Address 1000 Brookfield ave
(c) 9-2-1944 (Date rec'd by Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/1 1944 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1944 to 9/1 1944 and that I last saw her alive on 9/31 1944.

Immediate cause of death Resp. failure — Duration 2-7 hrs
Due to Uremic syndrome — 2 days
Due to Diabetes mellitus — ? yrs
Other Conditions Paralytic ileus — 2 days
(Include pregnancy within 3 months of death)

Date of operation 8/9
Major findings of operation: Diabetes gangrene - 2 md left toe.
or autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature W. D. Lynn M. D.
Address University Hospital Date signed 9-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20528 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County /
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 816 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Negro	M

6 (b) Name of husband or wife Carrie Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1880

8. AGE: Years	Months	Days	If less than one day
64 63			hr. min.

9. Birthplace St Mary's Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Carrie Dorsey
(b) Address 1315 E. Madison St

17 (a) Burial (b) Date thereof 9/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brookfield Ave

SEP 6 - 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944 at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944 to Sept 4 1944, and that I last saw him alive on Sept 4 1944

Immediate cause of death	Duration
Cardiac decompensation	
Due to Hypertensive cardio-vascular disease	
Due to	
Other Conditions Cerebro vascular accident	4 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
33. Signature J. R. Guyther
Address Mercy Hosp Date signed 9/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

G20529

BALTIMORE CITY HEALTH DEPARTMENT X V G20529

CERTIFICATE OF DEATH 93D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Jenkins Memorial Hospital
(c) Hospital or institution: 1000 Caton ave.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Co. George
(c) City or town Mt RAINER.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 25th St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Cecilia Rose

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: David Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1870

8. AGE: Years 74 Months 2 Days 5 If less than one day hr. min.

9. Birthplace Ireland (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Kelroy

13. Birthplace Ireland

MOTHER 14. Maiden Name Bridget Kelly

15. Birthplace Ireland

16 (a) Informant Sr. M. Cyril Sister

(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9/6/44 (month) (day) (year)

(c) Cemetery or crematory FORT LINCOLN. CEM.

Location WASH BLVD & D. C. LINE.

18 (a) Funeral director JOHN R. KENNY

(b) Address 1242 REEDS TER. HYATTSVILLE MD

19 (a) 9-6-1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1944, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/30 1944 to 9/4 1944 and that I last saw her alive on 9/4 1944.

Immediate cause of death: Heart failure — Duration

Due to: Chronic myocarditis — Duration

Due to: Arteriosclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M.D.

Address St. Agnes Hosp. Date signed 9/11/44

G20530

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 81a

Registered No. G20530

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Adams
(c) City or town New Oxford
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL POTTER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1877

8. AGE: Years	Months	Days	If less than one day
67	0	19	hr. min.

9. Birthplace Zullinger Pa.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Daniel C. Potter
13. Birthplace Pa.

MOTHER
14. Maiden Name Nancy Shank
15. Birthplace Pa.

16 (a) Informant Mr. Cyrus H. Potter
(b) Address New Oxford Pa.

17 (a) Burial (b) Date thereof Sept 8 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Hill
Location Waynesboro Pa.

18 (a) Funeral director Walter G. Grove
(b) Address 27 Church St. Waynesboro Pa.

19 SEP 6-1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1944, at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1944, to 9/5 1944, and that I last saw h. alive on 9/5 1944.

Immediate cause of death	Duration
Pneumococcic meningitis	
Due to	
Due to	
Other Conditions Pulmonary tuberculosis Uremia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy: SAME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature A. Robert Mark M. D.
Address Univ. Hospital Date signed 9/5/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓

Registered No. G20531

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 W. Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 212 W. Chase
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Gruden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Woodruff - Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name August Duckett
13. Birthplace Charles Co - Md

MOTHER
14. Maiden Name Sarah Yates
15. Birthplace Charles Co Md

16 (a) Informant Mrs. Maude Duckett family
(b) Address 1947 Columbian Ave Chicago

17 (a) Burial (b) Date thereof 9-6-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Mrs. Hattie R. Williams
(b) Address 322 N. Calvert St

19 (a) Date received by registrar SEP 6 1944 (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH August 23 1944, at 12 noon P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ... death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Graham M.D.
Medical Examiner.
Date signed August 24, 1944

G20532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G20532 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ella Douthat (Ellen Douthat)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: ~~Single~~ Widowed

6 (b) Name of husband or wife: Henry E. Douthat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1872

8. AGE: Years 71 | Months 10 | Days 5 | If less than one day ######## min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name William Blakeney
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Frances A. Crosbie
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Catharine Washington
(b) Address 1308 E. Lafayette Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave. Balto; Md

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

SEP 6 - 1944 (Date rec'd by registrar) Hunting for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6-44 19 , at 1:50a M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-44 19 , to 9-6-44 19 , and that I last saw her alive on 9-5-44 19 .

Immediate cause of death: Diabetic Coma — Duration:

Due to: Diabetes and a fall causing multiple contusions & fracture of right arm.

Other Conditions: Fractured right arm
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 8-28-44 at M
(c) Where did injury occur? home (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work?
(e) Means of injury Fell down steps

23. Signature Frank L. Vanni M. D.
Address St. Joseph's Hosp. Date signed 9-6-44

For St. N.M. Hall by Thomas J. Mullen, M.D.

G20533 — BALTIMORE CITY HEALTH DEPARTMENT — G20533 Registration No.

CERTIFICATE OF DEATH 49a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secours Hosp.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 hour
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No) If yes, name country

3 (a) FULL NAME Bessye Williams

3 (b) If veteran, name war ✓ (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Wm. A. Williams

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Jan 1, 1891

8. AGE: Years 53 | Months 8 | Days 0 | If less than one day ____ hr. ____ min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Home duties

11. Industry or business

FATHER — 12. Name Hooper
13. Birthplace Md.

MOTHER — 14. Maiden Name Rachel Owens
15. Birthplace Md.

16 (a) Informant Wm. A. Williams
(b) Address 626 N. Fulton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) Sept 6 1944
(c) Cemetery or crematory Mt. Olivet
Location Frederick ave

18 (a) Funeral director John A. Mitchell
(b) Address 1902 Eutaw Place

19 (a) Filed (Date received by registrar) SEP 6 1944 Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4 1944, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/4 1944 to 9/4 1944 and that I last saw her alive on 9/4 1944.

Immediate cause of death Peripheral Circulatory Failure — Duration 3 hrs.
Due to Generalized Cancer. metastasis — 1 yr.
Due to Carcinoma of Ovary. — ?
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury

23. Signature Edmund Boyer M. D.
Address Bon Secours Hosp. Date signed 9/11/44

28119
G20534

BALTIMORE CITY HEALTH DEPARTMENT G20534 Registered No.

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Broadway
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5da
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4403 Wickford Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Motz

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Rudolph Motz.
6 (c) If alive, give age 60 Years

7. Birth date of deceased (mo., day, yr.) 9-27-85

8. AGE: Years	Months	Days	If less than one day
58	11	12	hr. min.

9. Birthplace Md (Balto) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Gustav Siegmund
13. Birthplace Germany

MOTHER
14. Maiden Name Emile Hekman
15. Birthplace N.Y.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Putnam & Sons
(b) Address 2330 N. Charles St.

19 (a) SEP 6 - 1944 (Date rec'd by local reg.) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944 at 1 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1944 to Sept 4 1944 and that I last saw h alive on Sept 4 1944

Immediate cause of death	Duration
Respiratory arrest	
Due to Anemia, secondary	5 days
Due to Carcinoma cervix for advanced	2 years
Other Conditions Metastatic hydronephrosis & hydroureter, bilateral	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Carcinoma cervix - advanced

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Newton Long M.D.
Address The Johns Hopkins Hospital Date signed 9/4/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20535 Registered No.

111c

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3904 Forest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 64 yrs

1510

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3904 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hinkle Norris

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-8725

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence G. Norris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 30 1879

8. AGE: Years	Months	Days	If less than one day
64	11	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Hatter
11. Industry or business Mens Hats Inc.

FATHER
12. Name William Norris
13. Birthplace Harford Co Md

MOTHER
14. Maiden Name Lydia Grey Dutton
15. Birthplace Maryland

16 (a) Informant Florence G. Norris
(b) Address 3904 Forest Park Ave

17 (a) Burial (b) Date thereof Sep 7 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Harry K. Sherwood
(b) Address 4204 Ridgewood Ave
Huntington for Williams, M.D.

19 (a) SEP 6 1944 Registrar
(Date received)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 7 1944 to Sept 4 1944, and that I last saw h[illegible] alive on Sept 4 1944

Immediate cause of death	Duration
Cardiac Arrest.	6 hrs
Due to C.V.C. Lues.	2 weeks
Edema of Brain.	6 hrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Rowe M.D.
Address 936 N Fulton Ave Date signed 9/5/44

VS 150

G20536 ✓ G20536

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4222 Fernhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4222 Fernhill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Griffith Riffel

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-6881

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Florence M. Riffel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28/1869

8. AGE: Years	Months	Days	If less than one day: Hr.	min.
75	3	6		

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Secty Life Dept't Dept
11. Industry or business Nat Central Bank

FATHER
12. Name Thomas Riffel
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Griffith
15. Birthplace Baltimore Md

16 (a) Informant Florence M. Riffel
(b) Address 4222 Fernhill Ave

17 (a) Burial (b) Date thereof Sept 6/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director Harry A. Cameron
(b) Address 4204 Ridgewood Ave

19 (a) SEP 6 - 1944 Huntington Williams, Inc. 3902 Greenmount Ave
(Date filed by registrar) (Signature of funeral director) (Address)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/3 1944 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 9/3 1944 and that I last saw him alive on 9/3 1944.

Immediate cause of death Cancer of primary bladder
Duration 1 yr 5 yrs.
Due to cystic ureteral stasis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harvey R. Gaul M.D.
Date signed 9/4/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

C20537

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 55E

Registered No. C20537

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena,
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Waller (Myrtle M. Waller)

3 (b) If veteran, name war
3 (c) Social Security Account No. 262-18-9603

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	married

6 (b) Name of husband or wife James C. Waller
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) June 26, 1918

8. AGE: Years	Months	Days	If less than one day
26	2	11	hr. min.

9. Birthplace Pensacola Fla.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Own home

FATHER
12. Name Durwood Thompson
13. Birthplace Unknown

MOTHER
14. Maiden Name Nancy (Unknown)
15. Birthplace Unknown

16 (a) Informant James C. Waller
(b) Address Pasadena, Md. R.F.D.

17 (a) Ship (Burial, cremation, or removal) (b) Date thereof Sept 7,44 (month) (day) (year)
(c) ~~Cemetery or crematory~~ W.G. Turbyfill
Location Newport News, Va.

18 (a) Funeral director Thomas W. Quigley
(b) Address Glen Burnie, Md.

SEP 6 - 1944 (b)
(Date rec'd by Local Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1944, at 6 55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1944 to 9/5 1944 and that I last saw h[illegible] alive on 9/5 1944

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to Multiple Injuries	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Nodules in Both Lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address St Joseph Hospt Date signed 9/6/44

G20538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No. G20538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts. 20
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 59d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? O (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Theresa E. Wade

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: f | 5. Color or race: W | 6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Same - d.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-19-1864

8. AGE: Years 80 | Months 1 | Days 15 | If less than one day hr. min.

9. Birthplace Balto -
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Wm. John Fowler
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Coleman
15. Birthplace Md.

16 (a) Informant Mr. Walter A. Wade (Son)
(b) Address Same

17 (a) BURIAL (b) Date thereof SEPT. 6-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory MOUNT OLIVET CEMETERY
Location Baltimore, Md.

18 (a) Funeral director F. O. Wolfert Sons
(b) Address Baltimore, Maryland

19 (a) (Date received by registrar) SEP 6 - 1944 (b) Registrar's signature Huntington Williams M.D.

VS-10

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4 1944, at 1:A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-7 1944 to 9-4 1944 and that I last saw her alive on 9-4-44 19

Immediate cause of death	Duration
Cardia Rupture	
Failure -	
Due to Fractured Lt. Hip	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 7, 1944 at 9 P.M
(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? No.
(Specify type of place)
(e) Means of injury Fall to floor.

23. Signature Jack C. Morgan, M.D.
M. D.
Address Union Mem. Hosp. Date signed 9-4-44

Approved, Howard J. Andersen, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G20539 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 625 N. Ellwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto -
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 625 N. Ellwood Ave.
(If rural give location)
(e) Citizen of foreign country? No - (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Elizabeth Harrison

3 (b) If veteran, name war

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Married

6 (b) Name of husband or wife Laurence Edgar Harrison
6 (c) If alive, give age 70 years
7. Birth date of deceased (mo., day, yr.) May 20. 1874

8. AGE: Years	Months	Days	If less than one day
70	3	16	hr. min.

9. Birthplace Lisbon, Howard Co Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin F. Barnes
13. Birthplace Lisbon Md.

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Catonsville, Md.

16 (a) Informant Laurence E. Harrison
(b) Address 625 N. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month) (day) (year)
(c) Cemetery [redacted] McKendry
Location Cooksville, Md

18 (a) Funeral director Howard N. Blight, Jr.
(b) Address 2914 Belair Rd

19 SEP 6 - 1944 (Date rec'd by Local Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1944 at 1 35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Sept 4 1944 and that I last saw h[illegible] alive on Sept 4 1944.

Immediate cause of death: Carcinomatosis - Cancer of Breast - — Duration July 1942

Due to

Due to

Other Conditions arterio-sclerosis — July 1942

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: Treated by deep X-Ray + Radium

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed Sept 5/44

G20540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G20540

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Fort Street
(c) Hospital or institution: Balto. City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 631 S. Patterson Park Ave. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph P. Lindgren

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-10-0931

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1903

8. AGE: Years	Months	Days	If less than one day
40	10	4	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Rudolph Lindgren
13. Birthplace Sweden

MOTHER
14. Maiden Name Barbara Kiel
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Barbara Kiel
(b) Address 631 S. Patterson Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gerrmantown Road

18 (a) Funeral director M. F. Sadowski & Son
(b) Address 1808 Eastern Ave.

19 SEP 6 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5- 1944, at 6 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-2-44 at 4/1 P M.
(b) Where did injury occur? Balto. City Harbor, Pratt St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned.

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed 9-5-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 48a

Registered G20541

G20541

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3018 Louise Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3018 Louise Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Regina M. Weloff

3 (b) If veteran, name war No
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Weloff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1907

8. AGE: Years 37 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Peter Faust
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Margaret M. Laughlin
15. Birthplace Baltimore Md

16 (a) Informant Mr. John Weloff
(b) Address 3018 Louise Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4430 Belair Rd.

18 (a) Funeral director Edmund W. Conklin & Son
(b) Address 924 E. Eager St.

19 (a) SEP 6 - 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4, 1944, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jany 7 1944 to Sept 4 1944, and that I last saw h[illegible] alive on Sept 4 1944.

Immediate cause of death Cardio-Respiratory paralysis - Uterine hemorrhages — Duration 6 to Burke

Due to Carcinomatous Uterus cervix & adnexa — 6 to 8 mos

Due to

Other Conditions Operations & Transfusions Women's Hosp. past 6 mos

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Clifford Talbot M. D.
Address 5010 Greenleaf Rd Date signed 9-6-44

G20542

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G20542

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3947 Greenmount Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3947 Greenmount Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Irving Coleburn

3 (b) If veteran, name war

3 (c) Social Security Account No. 099-05-9534

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1889

8. AGE: Years 55 | Months 1 | Days 12 | If less than one day hr. min.

9. Birthplace Accomac Co. Virginia (Town, county, and state)

10. Usual Occupation Inspector, automotive

11. Industry or business War Dept - Camp Holabird

FATHER
12. Name Edward J Coleburn
13. Birthplace Va

MOTHER
14. Maiden Name Mary Clemmons
15. Birthplace Balto, Md.

16 (a) Informant
(b) Address

17 (a) ~~Burial~~ Burial (Burial, cremation, or removal) (b) Date thereof Sept 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Balto, Md.

18 (a) Funeral director D. J. Covington
(b) Address 2141 W. Mt. St. Huntington Williamsport, Md.

19 SEP 6 - 1944 (Date rec'd by registrar) (c) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1944 at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944 to Sept 4 1944 and that I last saw him alive on Sept 4 1944

Immediate cause of death: Coronary embolism — Duration: 1/2 hr.

Due to: Myocarditis — Duration: 6 yrs.

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius J. Saffell M. D.
Address 3712 Greenmount Ave Date signed Sept 4 44

C20543

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

Registered No. C20543

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dod.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 347 E. 22nd Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah M. Doughty

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward R

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11 1889

8. AGE: Years	Months	Days	If less than one day
55	6	24	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name James J Nassey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ida May Gilbert
15. Birthplace Unknown

16 (a) Informant Edward R. Doughty
(b) Address 347 E. 22nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Cathedral
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Fayette St

SEP 6 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1944 at 1:20 P M

21. I certify that I took charge of the remains described above, held an Inquiry & Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Death death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Sarcoma of throat

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Faulkner M.D. Medical Examiner.
Date signed Sept 5, 1944

G20544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20544

1. PLACE OF DEATH: Franklin Square Hosp.
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2556 Boyd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lilly Mae Hare

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Benjamin Hare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31st 1878

8. AGE: Years 65 | Months 10 | Days 3 | If less than one day: hr. min.

9. Birthplace: Georgetown D.C.
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business: Self

FATHER
12. Name: Unknown / Kerney
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Mrs. Moxley
(b) Address: 2556 Boyd st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month) (day) (year)
(c) Cemetery or crematory: St. Marys
Location: Hamilton

18 (a) Funeral director: William Cook Inc.
Address: 1217 St. Paul st

19 SEP 6 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/44 19 , at 8 77 M

21. I certify that death occurred on the date above stated) that I attended deceased from 9/3/44 19 to 9/4/44 19 , and that I last saw her alive on 9/4/44 19

Immediate cause of death: Congestive Heart Failure — Duration:
Due to: Arteriosclerotic Heart Disease
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Julius Gluck
Address: Franklin Square Hosp. Date signed 9/4/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

FG20545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √469

Registered No. G20545

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) SINCE Jan. 27, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 Greenmount Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME PERCY STANLEY ARMSTRONG

3 (b) If veteran, name war	3 (c) Social Security Account No.
World's War	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Wid.

6 (b) Name of husband or wife Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1891

8. AGE: Years	Months	Days	If less than one day
53	0	1	hr. min.

9. Birthplace Staunton, Va.
(Town, county, and state)
10. Usual Occupation -
11. Industry or business

FATHER
12. Name Percy S. Armstrong
13. Birthplace ? Va.

MOTHER
14. Maiden Name Rosa Long
15. Birthplace ? Va.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial [illegible] (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory National
Location Baltimore Md
18 (a) Funeral director Wilhoms & Son Inc
(b) Address 1217 E. Fayette St
19 (a) [illegible] 1944 (b) Huntington Williams M.D. Registrar
(Registrar)

SEP 6 1944

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH September 5, 1944 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 27, 1944, to Sept. 5, 1944, and that I last saw him alive on Sept. 5, 1944.

Immediate cause of death Caroinoma of the liver with metastases to the pancreas and left adrenal — Duration Sev. years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address Baltimore, Md. Date signed 9/6/44 M. D.

Va-14267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C20546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 164a

Registered No. C20546

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Altamont Hotel
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Altamont Hotel Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Allen N. Patterson

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, 1904

8. AGE: Years	Months	Days	If less than one day
40	0	0	hr. min.

9. Birthplace Bridgeton R. I
(Town, county, and state)
10. Usual Occupation Auto Mechanic
11. Industry or business

FATHER	12. Name Frank Patterson
	13. Birthplace Bridgeton R. I
MOTHER	14. Maiden Name Estella Knight
	15. Birthplace Bridgeton R.I.

16 (a) Informant Mildred Patterson
(b) Address 1245 Eutaw Place
17 (a) Removal (b) Date thereof 9/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pascoag
Location Pascoag R.I.
18 (a) Funeral director Wilhelm Corporation
(b) Address 129 E. Lexington St. Baltimore, Md.
19 SEP 6 - 1944 (b)
(Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5- 1944, at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-5-44 at 8 M.
(b) Where did injury occur? Altamont Hotel
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? no
(d) Means of injury Strangled by rope and electric iron cord
23. Signature Howard J. Weidner M.D.
Medical Examiner.
Date signed 9-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G20547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20547 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 522. N. Carey St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 522. N. Carey St (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Fe | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 26- 1897

8. AGE: Years 46 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name David Williams
13. Birthplace N.C.

MOTHER
14. Maiden Name Amanda
15. Birthplace N.C.

16 (a) Informant Mrs. Hattie Banks
(b) Address 522. N Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-6-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Arbutus - Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322. N. Schroeder

SEP 6-1944 (Date filed by registrar) Registrar for Williams Funeral

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 1944, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1944 to Sept 3 1944 and that I last saw h.e. alive on Sept 3 1944

Immediate cause of death Cerebral Hemorrhage — Duration 5 days
Due to Hypertension
Due to Uremia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Ralph W Pentony M.D.
Address 426 W. Lafayette Ave Date signed 9/6/44

VS 180

G20548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G20548

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2813 Greenmount avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2813 Greenmount avenue
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE HOLBROOK

3 (b) If veteran, name war: ---

3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Felix A. Holbrook
6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1867

8. AGE: Years 76 | Months 11 | Days 19 | If less than one day: ___ hr. ___ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name George H. Whitney
13. Birthplace New York

MOTHER
14. Maiden Name Jane Harrison
15. Birthplace Ireland

16 (a) Informant Mrs. Jane O'Brien
(b) Address 2813 Greenmount avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. L. Evans Son Inc
(b) Address 1618 N. Charles St.

19 (a) SEP 6 - 1944 (Date rec'd by registrar)
Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 4 1944 at ___ M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-16 1944, to Sept. 4th 1944, and that I last saw her alive on 9/2 1944.

Immediate cause of death: Myocardial Insufficiency — Duration: about 2 yrs.

Due to: ———

Due to:

Other Conditions: Arteriosclerosis — unknown

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jesse Montgomery M.D.

Address 401 E. 25th. Date signed 9/5/44.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20549 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 E. 25th St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William B. Hysan (William B. Hysan)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Sarah Ryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/1867

8. AGE: Years 77 | Months 6 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Secy. - Treas.

11. Industry or business Casey Machine Co.

FATHER 12. Name William B. Hysan

13. Birthplace Baltimore

MOTHER 14. Maiden Name Georgianna Kelly

15. Birthplace Baltimore

16 (a) Informant William B. Hysan, Jr.

(b) Address 225 Wendover Road

17 (a) Burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. B. Means & Son

(b) Address 805 N. Calvert Street

19 (a) (b)
(Date received by registrar) Registrar

SEP 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1944, at 2:30 AM

21. I certify that death occurred on the date above stated, that I attended deceased from 8/20 1944 to 9/5 1944, and that I last saw h.... alive on 9/5 1944.

Immediate cause of death: Uremia — Duration: 3 wks

Due to Arteriosclerosis C.V.D. and acute Urinary Retention

Due to

Other Conditions Suprapubic Cystostomy

(Include pregnancy within 3 months of death)

Date of operation 8/20/44

Major findings of operation: acute prostatic Urinary Retention

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. B. Gray M.D.

Address Mercy Hosp. Date signed 9/5/44

G20550 BALTIMORE CITY HEALTH DEPARTMENT G20550

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3815 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 12 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3815 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

15 9

3 (a) FULL NAME BERTHA LEWENSOHN ROSS.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Maurice Ross.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 27, 1874.
8. AGE: Years 70 | Months 1 | Days 9 | If less than one day hr. min.
9. Birthplace London, England. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Meyer Lewensohn,
13. Birthplace Germany.

MOTHER
14. Maiden Name Rosalie Philipson,
15. Birthplace Germany.

16 (a) Informant Miss. Carolyn Lewensohn,
(b) Address 3815 Clifton Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Balto. Md.
18 (a) Funeral director Harris Levenson & Son
(b) Address 1902 Eutaw Place.
19 (a) Date received (b) Huntington Williams, M.D. Registrar
SEP 6 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1944, at 9:25 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/5 1935, to 9/5 1944, and that I last saw h[illegible] alive on 9/3 1944.

Immediate cause of death: Coronary occlusion — Duration: 1 day
Due to: Arteriosclerosis — 10 yrs
Due to: Hypertension — 12 yrs
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Frank Levenson M. D.
Address 4004 Auburn & Hayes Ave Date signed 9/5/44

CLARENCE PRESTON ALBAN

G20551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 107

Registration No. G20551

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 828 Wellington St. #11
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Preston Alban

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-7978

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lydia B. Alban
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1892

8. AGE: Years	Months	Days	If less than one day
51	9	1	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Ry. R.R.
11. Industry or business Asst. Yard Master

FATHER
12. Name George H. Alban
13. Birthplace Md.

MOTHER
14. Maiden Name Alice L. Little
15. Birthplace Md.

16 (a) Informant Mrs. Sophia B. Alban
(b) Address 828 Wellington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 8-1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore Co. Md.

18 (a) Funeral director Burge Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Mgr. Registrar

SEP 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/4/1944, at 10 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3/1944, to 9/4/1944, and that I last saw h. alive on 9/4/1944.

Immediate cause of death	Duration
Respir. Failure	
Due to Overwhelming Pneumonia	
Due to (a)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo S. Gallagher for MD M. D.
Address Md Gen Hosp Date signed 9/5/44

LEO S. GALLAGHER, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BRIDGET MARY MORRISSEY

G20552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V186a

G20552 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3632 Roland Ave
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Bridget Mary Morrissey

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE:	Years	Months	Days	If less than one day
about	86	-	-	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Morrissey
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Lynch
15. Birthplace Ireland

16 (a) Informant Dr. John J. Morrissey
(b) Address 3262 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 7-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3231 Fallsway

19 (a) SEP 6 - 1944 (Date rec'd by registrar) (b) Registrar's signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944, at 11 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1944 to Sept 4 1944 and that I last saw her alive on Sept 4 1944

Immediate cause of death	Duration
Acute Respiratory Failure	
Due to Lobular Pneumonia	
Due to Staphylococcus Aureus Septicemia	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 8/31/44

Major findings of operation Exploration of Upper Abdomen

of autopsy: Will be sent

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Aug 27 1944 M
(c) Where did injury occur? Baltimore City Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work?
(Specify type of place)
(e) Means of injury Fall on bathroom

23. Signature William H. Lippitt M. D.

Address Union Memorial Hosp. Date signed 9/4/44

Approved, Robert Lee Pentuke M.D. 9/7/44

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20553 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution:
So. Balto. Gen. Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. West St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Kluka

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-23-44

8. AGE: Years	Months	Days	If less than one day
		11	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Henry A. Kluka
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Frances A. Nicolaus
15. Birthplace Balto., Md.

16 (a) Informant Mother
(b) Address Above

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 6 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1944, at 5:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1944 to 9-3 1944 and that I last saw him alive on 9-3 1944.

Immediate cause of death Atelectasis (Pulmonary) — Duration

Due to Premature Newborn

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles B. MacDaniel, M.D.
Address So. Ba. He. Gen. Hosp. Date signed 9/5/44

2138

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G20554

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20554

CERTIFICATE OF DEATH 93d

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 Lambeth Rd
(c) Hospital or institution: Guilford
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Lambeth Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Barth

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Adolphus Barth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12 1860

8. AGE: Years 83 | Months 11 | Days 25 | If less than one day 4 hr. min.

9. Birthplace La Crosse Wis.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Stephan Gast
13. Birthplace —

MOTHER 14. Maiden Name —
15. Birthplace —

16 (a) Informant Mrs. Geo H. Emerson
(b) Address 210 Lambeth Rd

17 (a) Cremation (b) Date thereof Sept 6 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry M Jenkins & Sons
(b) Address McCulloh & Orchard Sts

19 Sept 7 1944 Huntington Williams, M.D.
(Date received by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1944, at 7 30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940, to Sept 6 1944, and that I last saw h.e. alive on Sept 6 19.

Immediate cause of death
(a) Cerebral Arteriosclerosis
Due to (b) Hypertension and Nephritis
Due to (c) —
Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No

Duration
1 month
4 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Cohalan
Address 620 E. Cathedral St. Date signed Sept 5 1944 M. D.

G20555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944

Registered No. G20555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 133 N Lombard
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 N. Lombard (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret A Creaghan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Widow.

6 (b) Name of husband or wife Patrick J Creaghan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1862

8. AGE: Years 81 | Months 11 | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick O'Brien
13. Birthplace Ireland

MOTHER
14. Maiden Name Myra A Smith
15. Birthplace Maryland

16 (a) Informant Miss M Creaghan
(b) Address 1321 N Lanvale

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Balto Md

18 (a) Funeral director John J Doherty & Sons
(b) Address 1318 Light St.

19 SEP 7 - 1944 (Date rec'd by registrar) (b) Clifton Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5th 1944, at 7:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31st 1944 to Sept. 5th 1944, and that I last saw her alive on Sept. 4th 1944

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to Benign prostatism	
Due to Arterio sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Upshur White M. D.

Address 3005 Hawk St. Date signed 9/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ 3/a

G20556 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 N. Arlington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) " 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 622 N. Arlington Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Oliver Bond

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 213-03-8568

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Eleanor
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) 5/1/1879

8. AGE: Years 65 | Months 4 | Days 2 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Driver 1 E Pratt St
11. Industry or business Kodesky & Son

FATHER
12. Name Oliver Bond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sarah
15. Birthplace Baltimore Md

16 (a) Informant Eleanor Bond Wife
(b) Address 622 N. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-44 (month) (day) (year)
(c) Cemetery or crematory Dem Cathedral
Location Baltimore Md

18 (a) Funeral director Charles S. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Date received SEP 7 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1944, at 11:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Sept 3 1944, and that I last saw him alive on Sept 3 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	
Arteriosclerosis	
Due to Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Davidson M. D.
Address 805 N Fremont Date signed 9.6.44

G20557

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 461

G20557 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 Warner St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Warner St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co. Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business Laborer

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Ella Smith
(b) Address 920 Warner St

17 (a) Burial (b) Date thereof Sept 8-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Stamos
(b) Address 142 W Lee St

19 (a) (b) Huntington Williams, M.D.
(Signature of registrar)

SEP 7 - 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 19 , at 2.35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 19 44 to Sept 4 19 44
and that I last saw him alive on Sept 3 19 44

Immediate cause of death: Acute nephritis — Duration: 3 Wks
Due to: Not determined (Terminal condition)
Due to:
Other Conditions: Carcinoma of Colon
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature John W. Jaimes M.D.
Address 648 W. Baltimore St Date signed 9/6/44

G20558 459842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 86

G20558 Registered No.

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: J. Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David K Strauss.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-29-44

8. AGE: Years	Months	Days	If less than one day
	3	9	hr. min.

9. Birthplace md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Herman Strauss.
13. Birthplace md.

MOTHER 14. Maiden Name Doris Schwartz
15. Birthplace md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-[illegible]-44 (month) (day) (year)
(c) Cemetery or crematory Druedale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

SEP 7 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 7 1944 at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 27 1944 to Sept 7 1944, and that I last saw him alive on Sept 7 1944.

Immediate cause of death: infantile tetany — Duration: 2 weeks
Due to:
Due to:
Other Conditions: cerebral hemorrhage ? (Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Joel Koenig M. D.
Address Johns Hopkins Hosp Date signed 9-7-44

Luckabaugh X V

G20559

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G20559

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Audrey Luckabaugh

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 - 1941

8. AGE: Years: 3 | Months: 11 | Days: 10 | If less than one day: hr. min.

9. Birthplace Westminster Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Harry Luckabaugh.
13. Birthplace Carroll Co.

MOTHER
14. Maiden Name Helen Reed.
15. Birthplace Carroll Co.

16 (a) Informant Harry Luckabaugh
(b) Address 8627 Old Harford Rd.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 9/9/44 (month) (day) (year)

(c) Cemetery or Crematory Emmanuel Lutheran Church
Location Manchester Md.

18 (a) Funeral director Geo Lemmon
(b) Address 525 N Eutaw St Baltimore

19 (a) SEP 7 1944 (b) Registrar Huntington Williams, M.D.
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1944, at 11 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [redacted] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of skull; Fracture of both [redacted] legs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury September 4, 1944 3 P.M. (Approx.)
(b) Where did injury occur? Route 30, Hampstead
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? —
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept. 5, 1944

G20560

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

153

Registered No. G20560

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Washington, D.C.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA Goldstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Kroft
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Hospital Records.
(b) Address

17 (a) Removal (b) Date thereof 9 7 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Washington, D.C.

18 (a) Funeral director B. Bamansky
(b) Address 3501-14th St. N.W. Wash. D.C.

19 SEP 7 1944 (b) Huntington Williams, M.D.
(Date filed by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6- 1944 at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1944 to 9-6 1944 and that I last saw h[illegible] alive on 9-6 1944

Immediate cause of death Pulmonary edema — Duration

Due to Puerperal toxemia

Due to Pemphigus vulgaris — 5 weeks

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron J. Myers M. D.
Address Sinai Hospital Date signed 9-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G20561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 730

G20561 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai Hosp. 2W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 E. Montgomery St.
(If rural give location)
(e) Citizen of foreign country? N.G. (Yes or No)
if yes, name country

3 (a) FULL NAME Wm. M. Marek

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Mildred R. Marek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 27 1881

8. AGE: Years	Months	Days	If less than one day
63	6	8	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation Funeral Director
11. Industry or business John F. Denny, Inc.

FATHER
12. Name Frank Marek
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Bertha Key
15. Birthplace Unknown

16 (a) Informant Miss Fannie Elizabeth Marek
(b) Address 718 Montgomery St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.

18 (a) Funeral director Earl L. Fleegs
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsport, Md.

SEP 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 19 44, at 11 22 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 19 44, to 9/5 19 44, and that I last saw h/ alive on 9/5 19 44.

Immediate cause of death Uremia

Due to ?

Due to

Other Conditions Severe anemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Earl Myers
Address Williamsport, Md. Date signed 9/6/44

G20562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

Registered No. G20562

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3052 Arunah Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3052 Arunah Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James William Dooley

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-3536

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary Elizabeth

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 2, 1891

8. AGE: Years 63 | Months 4 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Caruso Cork & Seal

FATHER
12. Name Bert Dooley
13. Birthplace Virginia

MOTHER
14. Maiden Name Rozene Carter
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Mary E. Dooley
(b) Address 3052 Arunah Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cemetery
Location Windsor Mill Road

18 (a) Funeral director Earl L. Hess
(b) Address 215 Light St.

19 (a) SEP 7 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5, 1944, at 7:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ... at ... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept. 5, 1944

(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - G20563

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20563 Registered No.

CERTIFICATE OF DEATH 137W

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 19
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5304 Carter Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Gilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, ~~1869~~ 1870

8. AGE: Years	Months	Days	If less than one day
74	.8	5	hr. min.

9. Birthplace N. Y.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Patrick Gilson
13. Birthplace Ireland

MOTHER
14. Maiden Name ?
15. Birthplace Ireland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-8-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Ed Humane
Location

18 (a) Funeral director L. S. Ruck
(b) Address 5215 Harford Rd Huntington Williams Mort

19 (a) SEP 7 1944 Registrar
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1944, at 7:35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18 1944, to 9-6 1944, and that I last saw him alive on 9-6 1944.

Immediate cause of death Pneumonia — Duration 2 Days
Due to
Due to
Other Conditions Prostatic enlargement with urinary obstruction
(Include pregnancy within 3 months of death)
Date of operation 9-4-44
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hauch L. Belton M. D.
Address Balt. City Hosp Date signed 9/6/44

G20564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 462

G20564 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Calvert St.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 50

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2921 Glendale Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Malone Mongin

3 (b) If veteran, name war —

3 (c) Social Security Account No. 058-05-3217

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Marguerite V. Mongin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1876

8. AGE: Years 68 | Months 6 | Days 1 | If less than one day — hr. — min.

9. Birthplace Savannah Ga.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Robert McMongin
13. Birthplace Ga.

MOTHER 14. Maiden Name Anna Ridgeley
15. Birthplace Ga.

16 (a) Informant Mrs Marguerite Mongin
(b) Address 2921 Glendale Ave

17 (a) BURIAL (b) Date thereof 9-7-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory PARKWOOD
Location

18 (a) Funeral director J. J. Ryck
(b) Address 5205 Harford Rd.

19 (a) (Date rec'd by registrar) SEP 7 1944 (b) Huntington Williams Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1944 at 12:5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1944 to 9/6 1944, and that I last saw him alive on 9/6 1944

Immediate cause of death Acute circulatory Failure — Duration 24 hrs.

Due to Intestinal Obstruction — 2 wks.

Due to Probable Ca Sigmoid — Undetermined

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert E. McFaddin M.D.
Address Mercy Hospital Date signed 9/6/44

G20565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G20565 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Gold St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 514 Gold St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Burke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Thomas B. Burke Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 6 - 1881

8. AGE: Years	Months	Days	If less than one day
63	5 7	29	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unk.
13. Birthplace

MOTHER
14. Maiden Name Ellen Ridley
15. Birthplace Frederick Md

16 (a) Informant Mrs Margaret Brown
(b) Address 312 Presstman st

17 (a) Burial (b) Date thereof 9-8-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn Cem
Location Westport Balto Md

18 (a) Funeral director George T. O. Lytton
(b) Address 1350 Hanover Ave

19 (a) SEP 7 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5 1944 at 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1944 to 9/5 1944, and that I last saw her alive on 9/3 1944

Immediate cause of death Cerebral
Due to apoplexy
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ben Clutts M. D.
Address 213 Druid Hill Ave Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 13 0

G20566 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. DO NOT WRITE IN SPACE RESERVED FOR STAMPING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. county
(c) City or town 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6409 Blankman Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Engelhardt.
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Wid

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7 1867

8. AGE: Years	Months	Days	If less than one day
76	8	29	hr. min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Richard E Henderson
13. Birthplace Md.

MOTHER
14. Maiden Name Matilda Redman
15. Birthplace Md.

16 (a) Informant Katie Bartholomae
(b) Address 6409 Blankman Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9/44 (month, day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John Crutchfield Home
(b) Address 1900 Eutaw Place

19 (a) (Date received by registrar) SEP 7 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1944 to 9/6 1944
and that I last saw h~~er~~ alive on 9/5 1944

Immediate cause of death	Duration
Cardio-Resp failure.	
Due to Arteriosclero. Card. Renal dis.	
Due to uremia, Hemm. pneumonia.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Hemm. pneum., Card-Resp Dis, Pathy mineral

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. James DeLong M. D.
Address Mercy Hospital Date signed 9-7-44

G20567

JL - 89585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20567

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Eden St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Infant Gee~~ Oritha Clark Gee

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 17, 1921

8. AGE: Years	Months	Days	If less than one day
23	4	17	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Daniel Clark
13. Birthplace Va.

MOTHER
14. Maiden Name Viola Holcomb
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke
(b) Address 1304 E. Central Ave.

SEP 7 - 1944
(Date rec'd by registrar)
(a) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-4 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1944, to 9-4 1944, and that I last saw h~~er~~ alive on 9-4 1944

Immediate cause of death Far advanced Bilateral Pulmonary Tuberculosis — Duration 7

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Some

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Shea Halle

Address BCH Date signed M. D. 9/5/44

G20568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194 N

G20568 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St
(c) Hospital or institution:
Home for Incurables - B
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 M 19 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md - (b) County
(c) City or town Balto -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 700 W 40th St
(If rural give location)
(e) Citizen of foreign country? Md - (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Stuart Smith. (Mrs. C. Wharton Smith)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widowed

6 (b) Name of husband or wife C. Wharton Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-22-1865

8. AGE: Years	Months	Days	If less than one day
79	7	7	hr. min.

9. Birthplace Baltimore Md -
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Johns Hopkins Janney
13. Birthplace Virginia

MOTHER
14. Maiden Name Carolyn Symington
15. Birthplace Baltimore md

16 (a) Informant Mrs. C. Wharton
(b) Address 700 W. 40th ST.

17 (a) Burial (b) Date thereof Sept 8 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Darlington
Location Darlington Md

18 (a) Funeral director Henry M Jenkins Son Co
(b) Address McCulloh & Orchard

19 (a) (Date rec'd by registrar) (b) Huntingdon Hillcrest Md
Registrar
SEP 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1944, at 12 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1944 to 9/6 1944, and that I last saw her alive on 9/6 1944.

Immediate cause of death	Duration
Coronary Occlusion	1 Hour
Due to Arteriosclerosis (Hem-)	15 years
Due to Hypertension (Essential)	15 years
Other Conditions Cerebral Vascular accidents (Hemorrhage)	5 years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Grafton Hergrye M. D.
Address 214 Medical Arts Bldg Date signed 9/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20569

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 George St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 George St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 3, 1872

8. AGE: Years: 72 | Months: 6 | Days: 1 | If less than one day: hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: William Offer
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Rachel Waters
15. Birthplace: Baltimore Md

16 (a) Informant: William Harrison
(b) Address: 800 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 8/44 (month) (day) (year)

(c) Cemetery or crematory: Mt. Auburn Cem

Location

18 (a) Funeral director: Mrs Robert A. Elliott - Dft

(b) Address: 1209 N. Caroline St

SEP 7 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7-44 19 . A. M. P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28-44 to 9-7-44,
and that I last saw h 9-[illegible]-44 19 .

Immediate cause of death: Cardiac Failure, due to Hypertension

Duration: 10 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: A. C. Ellis M. D.
Address: 800 [illegible] Date signed: 9/7/44

G20570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1/31b

G20570 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 W. Lafayette
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1012 W. Lafayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Langford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1907

8. AGE: Years	Months	Days	If less than one day
36 37	11	24	hr. min.

9. Birthplace Jacksonville Fla (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Sarah Wallace Tabourn
(b) Address 909 N Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph G. Lively
(b) Address 4629 Mount Street

19 SEP 7 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1944, at 9:25 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic nephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Sept. 5, 1944

G20571

JL - 24561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 197

Registered No. G20571

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 -2- 8

(e) Length of stay in Baltimore (yrs., mos., or days) Life

26-13

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Frank Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1862 (82)

8. AGE: Years 75 ? | Months ? | Days ? | If less than one day: hr. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Sandy Young

13. Birthplace Md.

MOTHER

14. Maiden Name Hennie ?

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month) (day) (year)

(c) Cemetery or crematory Forest Lawn

Location Balto Co. Md.

18 (a) Funeral director J. S. Fahey Sons

(b) Address 1818 Light St.

19 SEP 7 - 1944 (Date Rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/2/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-13 1944 to 8-31 1944 and that I last saw him alive on 8-31 1944

Immediate cause of death Uremia & Bronchopneumonia — Duration

Due to Arteriosclerosis Gangrene

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8-13-44

Major findings of operation:

Arteriosclerosis gangrene

of autopsy: right foot

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature A. Cutler

Address East City Hosp Date signed 9-5-44 M. D.

G20572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 478

G20572
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1900 Eastern Avenue
(c) Hospital or institution:
Residence of Dr. Gerling
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1900 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Young

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 5-15-84 1884
8. AGE: Years 60 | Months 3 | Days 20 | If less than one day: hr. min.
9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Jonah Young
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Conrad Gelois
15. Birthplace Baltimore Md.

16 (a) Informant Dr. Gerling
(b) Address 1900 Eastern Ave

17 (a) BURIAL (b) Date thereof SEPT. 8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location END OF EAST NORTH AVE.

18 (a) Funeral director Lilly & Zeile Sons
(b) Address 703 E. Wolfe Street.

19 (a) (Date rec'd by registrar) (b) Huntington Woods Williams, M.D. Registrar

SEP 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5-1944, at 11/45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-1944, to 9-5-1944, and that I last saw her alive on 9-2-1944

Immediate cause of death: Pulmonary edema

Duration: 1 day

Due to: Complications of Injury

Due to: (Other)

Other Conditions: Chronic malabsorption syndrome, duodenal ulcer
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard Lilly M. D.
Address Lilly Home & Hospital Date signed 9-7-44

G20573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20573

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2031 E. Pratt Street
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2031 E.PRATT ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David F. Crispens

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. none

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna M.Crispens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/9/89

8. AGE: Years 55 | Months 1 | Days 27 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation RETIRED CITY POLICE

11. Industry or business B.P.D.

FATHER
12. Name DAVID CRISPENS
13. Birthplace BALTO.

MOTHER
14. Maiden Name LOUISE VOGT
15. Birthplace BALTO.

16 (a) Informant ANNA M.CRISPENS (WIFE)
(b) Address 2031 E.PRATT ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT.9/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN
Location EASTERN AVE.EXT.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.WOLFE ST.

19 (a) (b)
(Local registrar) Registrar

VS-1b SEP 7 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH SEPT. 6/ 1944, at 6/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944 to Sept 6 1944, and that I last saw h.m alive on Sept 5 1944.

Immediate cause of death: Mitral Insufficiency
Condition Hypertrophy
Due to: Hypertension
Arteriosclerosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Toomey M.D.
Address 4441 W. Ellwood Ave Date signed 9/7/44

174306 G20574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

Registered No. G20574

MARG... RESERVED FOR ENDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Johns Hopkins
(c) Hospital or Institution: Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1120 Comet St (If rural, give location)
(e) Citizen of foreign country? Comet (Yes or No) If yes, name country

3 (a) FULL NAME John Reese

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-04

8. AGE: Years 39 | Months 0 | Days 0 | If less than one day hr. min.

9. Birthplace Ala. (Town, county and state)

10. Usual Occupation Dresser transfer

11. Industry or business

FATHER 12. Name John Reese

FATHER 13. Birthplace Ala.

MOTHER 14. Maiden Name Reese ?

MOTHER 15. Birthplace Ala.

16 (a) Informant Records. (b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-7-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elmer O. Wilson

(b) Address 1000 Brantley Ave

19 (a) (Date rec'd by registrar) (b) Huntington Woods Registrar

SEP 7 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3 1944 at 11:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1944 to Sept 3 1944, and that I last saw h alive on Sept 3 1944.

Immediate cause of death [illegible] — Duration

Hypertensive C.V. disease

Due to Uremia due to ? arteriolonephrosclerosis

Due to ? chronic glomerulonephritis

Other Conditions history of syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy not yet reported

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature John R Bringham M. D.

Address 1 If St Date signed 9/7/44

G20575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G20575 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 717 Bruce St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma V. Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: James Wilson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1875

8. AGE: Years 68 | Months 8 | Days 11 | If less than one day — hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Alexander Brown
13. Birthplace Md

MOTHER
14. Maiden Name Susan Riley
15. Birthplace Md

16 (a) Informant Boyd Wilson
(b) Address 717 Bruce St

17 (a) Burial (b) Date thereof 9/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O Wilson
(b) Address 1000 Bentley and Thurlington Wilson

19 (a) SEP 7 (b) 1944
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Bowel

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fontaine M.D.
Medical Examiner.
Date signed Sept. 5, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 9H a

G20576 Registered No. 6207

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Maryland General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. d. a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County [illegible] Balto City
(c) City or town Baltimore [illegible] (If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] 1019 N. Eutaw Street
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Homer Wayford

3 (b) If veteran, name war

3 (c) Social Security Account No. 107-10-7380

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rowena Hayes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1878

8. AGE: Years	Months	Days	If less than one day
66	-	24	hr. min.

9. Birthplace N. Y. (Town, county and state)

10. Usual Occupation Electrician

11. Industry or business Shipyard

FATHER
12. Name Hayford
13. Birthplace Rensselaer N. Y.

MOTHER
14. Maiden Name Rachel Griffin
15. Birthplace Rensselaer N. Y.

16 (a) Informant Mrs. Rowena D. Hayford
(b) Address Rensselaer, New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/7/44 (month, day, year)
(c) Cemetery or crematory Columbia Lot Clinton Hgts. N. Y. Greenmount Cem.
Location Clinton Hgts.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna Ave.

19 (a) SEP 7 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1944, at 12:05 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis ?

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Waldenmaier M.D. Medical Examiner.
Date signed Sept. 7, 1944.

G20577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 55L

Registered No. G20577

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Orems Rd.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Jacob Dollman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Wh	married

6 (b) Name of husband or wife Phoebe Dollman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15-1871

8. AGE: Years	Months	Days	If less than one day
72 73	8	20	hr. min.

9. Birthplace Austria Hungary (Town, county, and state)
10. Usual Occupation Ret. Farmer
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Phoebe Dollman
(b) Address 1115 Orems Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Belair Rd.

18 (a) Funeral director John P Connelly
(b) Address 419 Eastern Ave. Essex

19 (a) SEP 7-1944 (b) Registrar Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5, 1944 at 1:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/2 1944 to 9/5 1944, and that I last saw him alive on 9/4/1944.

Immediate cause of death Cachexia - Pancreatitis — Duration

Due to Parotid malignancy

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Murray Levine M.D.
Address Sinai Hosp Date signed 9/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G20578

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G20578 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARROW RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 Woodward St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give county)
(d) Street No. 817 Woodward St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LORRETTA J. KIRDY

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: FEM | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife WM. J KIRDY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN 29 1888

8. AGE: Years 56 | Months 7 | Days 7 | If less than one day hr. min.

9. Birthplace BALTO MD (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name JOS. MURRAY

13. Birthplace UNKNOWN

MOTHER 14. Maiden Name MARY STEWART

15. Birthplace UNKNOWN

16 (a) Informant WILLIAM J KIRDY

(b) Address 817 Woodward St

17 (a) Burial, cremation, or removal Baltimore (b) Date thereof 9-9-1944

(c) Cemetery or crematory Holy Cross Cem. Co.

Location

18 (a) Funeral director John B. Kerlin

(b) Address 1917 E. Fort Ave.

19 (a) SEP 7-1944 (Date rec'd by registrar) Waiting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1944 at 10 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1943 to Sept 6 1944. and that I last saw her alive on Sept 6 1944

Immediate cause of death	Duration
8 Generalized carcinomatosis	1 yr.
Due to Primary in Breast	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Kerlin M. D.

Address 57 S. Fulton Ave Date signed 9-7-44

G20579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20579 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1921 W. Lombard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Arthur J. McColgan

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Widowed

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9/12/70

8. AGE: Years	Months	Days	If less than one day
74	11	23	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Plumber

11. Industry or business Self

FATHER
12. Name Michael J. McColgan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary
15. Birthplace Ireland

16 (a) Informant Mrs. Gladys Schriefer
(b) Address 1921 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Thos. J. Kenny
(b) Address Hollins & Gilmor

19 (a) SEP 7 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/5/44 at 9:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/26/44 to 9/5/44 and that I last saw h[illegible] alive on 9/5/44.

Immediate cause of death	Duration
Coronary Occlusion	
Due to Generalized Arteriosclerosis	10 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thos. Norton Jr. M.D.
Address Bon Secours Hosp. Date signed 9/5/44

G20580 BALTIMORE CITY HEALTH DEPARTMENT G20580

CERTIFICATE OF DEATH 514

Registered No.

RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 N. Augusta Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 614 N. Augusta Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Karl. Rudpel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Mar

6 (b) Name of husband or wife Freda S. Rudpel

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) Feb 6 1895

8. AGE: Years 49 | Months 6 | Days 29 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name Aug. Rudpel.
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Schaaf
15. Birthplace Germany

16 (a) Informant Freda S. Rudpel
(b) Address 614 N. [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore and

18 (a) Funeral director J. Kemp Welch Son
(b) Address 300 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 SEP 7 - 1944 Huntington Wil

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5th 1944, at 5:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 15 1944 to Sept 5 1944, and that I last saw h[illegible] alive on Sept 5 1944.

Immediate cause of death Cardiac dilatation

Due to Carcinoma of Prostate with metastases to

Due to Liver

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: none performed

Duration
[illegible]
11 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph R. Zeuler M. D.
Address 2318 Eastern Ave Date signed 5/7/45

G20581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20581 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4231 Belmar Ave
(c) Hospital or institution: 4231

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4231 4731 Belmar Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Hammer

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Burkhardt J. Hammer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1857

8. AGE: Years 86 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name George Dauman
13. Birthplace Germany

MOTHER
14. Maiden Name Rosina Schellhouse
15. Birthplace Germany

16 (a) Informant Elsie R. Rumeshaft
(b) Address 4231 Belmar Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 8, 1944 (month, day, year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mc Nus. John W. Teufel Son
(b) Address 801 W. Fayette st.

19 (a) (Date received by registrar) (b) Registrar

VS 188 SEP 7 - 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 5 1944, at 11 45 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28 1944 to Sept 5 1944. And that I last saw her alive on Sept 5 1944.

Immediate cause of death	Duration
Acute pulmonary edema	2 days
Due to Chronic Myocardial decay	7 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A Lee Thebaut
Address 4116 Northern Pkwy Date signed 9/6/44 M. D.

3290 15 G20582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20582 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland JOHNS HOPKINS HOSPITAL
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 629 Ensor St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Braunon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Annamae Braunon
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 12-19-02

8. AGE: Years 41 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace S. C. (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Sam Braunon
13. Birthplace (S.C.)

MOTHER 14. Maiden Name Priscilla ?
15. Birthplace (S.C.)

16 (a) Informant Friend
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-11-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md

18 (a) Funeral director Adolphus Halstead
(b) Address 918 Druid Hill Ave

19 (a) 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7-1944, at 8:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29-1944, to 9-7-1944, and that I last saw him alive on 9-7-1944

Immediate cause of death: Pulmonary infarction — Duration:
Due to: ? secondary infection
Due to: Hypertensive C.V. disease
Other Conditions: mild uremia
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Cunningham M. D.
Address J H H Date signed 9/9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G20583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 812 E. North Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 812 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie (Mary) Curley

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business At Home

FATHER 12. Name Hugh Curley
13. Birthplace Ireland

MOTHER 14. Maiden Name Mary McCarthy
15. Birthplace Ireland

16 (a) Informant Bernard Holmes
(b) Address 812 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Cathedral 9-8-1944
Location —

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 50 E. 22nd St

SEP 8 - 1944 (Date rec'd by Registrar) (Huntington Williams, M.D. Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 1944 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Sept. 5 1944 and that I last saw h[illegible] alive on Sept. 5 1944

Immediate cause of death Carcinoma of left breast — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Grenzer M. D.
Address 1402 E. Lanvale Date signed 9-7-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20584

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20584

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D C (b) County
(c) City or town Washington (If outside city or town limits write RURAL and give town)
(d) Street No. 1775 I St. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cornelius Webb

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 2-28-76

8. AGE: Years: 68 | Months: 6 | Days: 7 | If less than one day: hr. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual Occupation: Dept. Agriculture

11. Industry or business

FATHER — 12. Name: John Webb
13. Birthplace: Va.

MOTHER — 14. Maiden Name: Mildred Bell
15. Birthplace: Va.

16 (a) Informant: Records.
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof: Sept 8 44 (month) (day) (year)
(c) Cemetery or crematory: Lincoln Cemetery
Location: Washington D.C.

18 (a) Funeral director: Thomas Thagins
(b) Address: 319 - R.I. ave N.W.

SEP 8 - 1944 (Date rec'd by registrar) Wilmington for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 5- 19 44 at 12 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 19 44 to Sept 5 19 44 and that I last saw h[illegible] alive on Sept 5 19 44

Immediate cause of death: Respiratory failure — Duration

Due to: Post op. pneumonia?

Due to: Ca of Stomach, ?
chronic bleeding & anemia.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/28/44

Major findings of operation: Inoperable Ca of stomach.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Robert D. Shaw, M.D.

Address: Johns Hopkins Date signed: 9/5/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR SENDING

VS 150

G20585

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

G20585 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Anny E. Berger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) 9/26/1875 ~~1877~~

8. AGE: Years	Months	Days	If less than one day
69	11	9	1 hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant CATHERINE HAMPER
(b) Address 432 E 22nd St

17 (a) Burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 SEP 8 - 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1944, at 11:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1944 to 9-5 1944 and that I last saw h[illegible] alive on 9-5 1944.

Immediate cause of death: Cardiorespiratory failure — Duration: ?

Due to: Leukemia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Leukemia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Myron J. Myers M. D.
Address Sinai Hospital Date signed 9-6-44

(over)

G20586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G20586 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGINS RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1117 S.Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1117 S.Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry J.Benner Jr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug.2,1944

8. AGE: Years	Months	Days	If less than one day
	1	4	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry J.Sr.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mildred Jungblut
15. Birthplace Baltimore

16 (a) Informant Father
(b) Address 1117 S.Decker Ave.

17 (a) Burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

SEP 8 - 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6.1944 19 , at M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/3 19 44 to 9/6 19 44
and that I last saw h alive on 9/5 19 44

Immediate cause of death

	Duration
Due to Staphylococcus Aureus Septicemia	7 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugh D. Hughes
Address 3323 E Balto St Date signed 9/7/44

G20587 330761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13/a

G20587 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address JOHNS HOPKINS HOSPITAL
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 401 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Hannie Duncan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-4-07

8. AGE: Years 37 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Cebow Duncan

13. Birthplace (S.C.)

MOTHER 14. Maiden Name Amelia ?

15. Birthplace (S.C.)

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Sept 9/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Camden S. Carolina

18 (a) Funeral director Mrs R. A. Elliott & Dgt.

(b) Address 1129 N. Gerrard St

SEP 8 - 1944 (b) Huntington Williamsburg, S.C. (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7- 1944, at 8:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28- 1944 to 9-7- 1944 and that I last saw h[illegible] alive on 9-7- 1944

Immediate cause of death Uremia, Nephritis

	Duration
Due to Chronic Glomerulo-nephritis Terminal	
Due to Hypertensive C.V. disease	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy OK - not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John B. Cunningham M. D.

Address JNH Date signed 9-7

G20588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

Registered No. G20588

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1929 N. Payson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days) 46 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 N. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JACOB ELLIS CAPLAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Ida
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Oct 5, 1885
8. AGE: Years 58 | Months 11 | Days 2 | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocery Store
11. Industry or business

FATHER
12. Name Nathan
13. Birthplace Russia

MOTHER
14. Maiden Name Dena
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location 6700 Block Reisterstown Rd

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) SEP 8 1944 (b) Washington Blvd

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7- 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1940 to Sept 7 1944 and that I last saw h[illegible] alive on Sept 7 1944.

Immediate cause of death: Apoplexy — Duration 10 hrs
Due to: Chr. nephritis with hypertension — 15 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jacob Caplan
Address 1804 Eutaw Place Date signed 9/8/44 (M. D.)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G20589

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 904 N. Fremont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 904 N. Fremont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Eva Campbell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1898

8. AGE: Years	Months	Days	If less than one day
46	3	-	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Campbell

13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Jones

15. Birthplace Virginia

16 (a) Informant Carla Clements

(b) Address 904 N. Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-10-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk

Location Balto. Co. Md.

18 (a) Funeral director Mortimer A. Heuisler

(b) Address 518 W. Baltimore St

19 (a) (Registrar's signature) (b) Huntington, Williams, Registrar

VS 101 SEP 8 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1944, at 3:35 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)

Date signed September 7, 1944.

G20590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20590 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1632 Ashburton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 Ashburton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE BERTHA UMSTAD

3 (b) If veteran, name war --
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Nace
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1867

8. AGE: Years	Months	Days	If less than one day
77	6	13	hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Muller
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. James Umstad
(b) Address 1632 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Baltimore, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(Date rec'd) SEP 8 - 1944 (By) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1944, at 1:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943, to Sept 6 1944, and that I last saw h-er alive on Sept 5 1944

Immediate cause of death Acute dilitation of Heart — Duration 1 day
Due to Myocarditis — 4 mo.
Due to Advanced arteriosclerosis — 9
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter S Tickner M. D.
Address 2220 Harrison Blvd Date signed Sept 7/44

G20591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G20591

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 441 S. Augusta Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 441 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA ELIZABETH VAUGHAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1874

8. AGE: Years	Months	Days	If less than one day
69	11	24	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Benjamin Vaughan
13. Birthplace Balto.

MOTHER
14. Maiden Name Martha Broadwater
15. Birthplace Balto.

16 (a) Informant Mrs. Laura C. Smith
(b) Address 433 Yale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 8 - 1944 (b) Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 5, 1944, at 6:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1944 to 9-5 1944 and that I last saw h[illegible] alive on 9/5 1944.

Immediate cause of death — Duration

Intracranial Hemorrhage

Due to Arterial Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Williams M. D.
Address 4209 Hunt Ave. Date signed 9-7-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M. D. F 1368-9

HEALTH DEPARTMENT—CITY OF BALTIMORE

G20592 G20592

CERTIFICATE OF DEATH 1927

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1713 De Sota Rd. St., ... Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Ursula Z. Watsuna

(a) Residence: No. 1713 De Sota Rd. St., 25-2 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F. | 4. Color or Race W | 5. Single, Married, Widowed or Divorced (write the word) Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Watsuna

6. DATE OF BIRTH (month, day, year) Oct 19, 1866

7. AGE: Years 78 | Months 10 | Days 17 | If LESS than 1 day ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. ✓

10. Date deceased last worked at this occupation (month and year) ✓ | 11. Total time (years) spent in this occupation ✓

12. BIRTHPLACE (city or town) (State or country) Lithuania

FATHER

13. NAME Vincent Victor

14. BIRTHPLACE (city or town) (State or country) Lithuania

MOTHER

15. MAIDEN NAME Kulpynas

16. BIRTHPLACE (city or town) (State or country) Lithuania

17. INFORMANT William Watsuna

(Address) 1713 De Sota Rd.

18. BURIAL, CREMATION, OR REMOVAL

Place Holy Redeemer Date 9/9/44

19. UNDERTAKER Charles W. Kuchenmeister

(Address) 637 Washington Blvd.

20. FILED ..... 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept. 6, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 28, 1940 to Sept. 6, 1944

I last saw h. er alive on Sept. 2, 1944 Death is said to have occurred on the date stated above, at 4:10 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arterio-sclerosis, essential	?
Chronic bronchitis	?
Chronic valvular heart disease	?

Other contributory causes of importance:

Myocardial insufficiency	4 days

Name of operation ..... Date of .....

What test confirmed diagnosis? Physical signs of death Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in **industry**, in **home**, or in **public place** .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? ..... If so, specify .....

(Signed) I. B. Bronushas, M. D. M. D.

(Address) 3037 O'Donnell St

V. S. 3

SEP 8 - 1944 Huntington Williams M.E.

G20593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G20593 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Rhodestown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-7-21
(e) Length of stay in Baltimore (yrs., mos., or days) 4-7-21

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Montgomery
(c) City or town Takoma Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 26 Dennwood avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James P. McGinness

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1869

8. AGE: Years	Months	Days	If less than one day
75	2	17	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Peter McGinness
13. Birthplace Ireland

MOTHER
14. Maiden Name Maria Green
15. Birthplace Washington D.C.

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Rhodestown Road

17 (a) Removal (b) Date thereof Sept 8 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director W.W. Deal Funeral Home
(b) Address 481 2d Ave. Wash D.C.

19 (a) SEP 8 - 1944 (b) Huntington Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1944, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1940, to Sept 7, 1944, and that I last saw him alive on Sept 7, 1944.

Immediate cause of death	Duration
Cardio-vascular collapse	
Due to myocardial infarct	3 wks
Due to	
Due to General arteriosclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Dewey P. Magruder M. D.
Address 3326 Tuckerman St. Date signed

VS 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G20594 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2012 Bank St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2012 Bank St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Fredrick Reitz

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-16-1331

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Frances
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Pepsi Blue Ribbon Beer

FATHER
12. Name George Reitz
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Carry
15. Birthplace Balto. Md

16 (a) Informant Frances Reitz
(b) Address 2012 Bank St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-44 (month) (day) (year)
(c) Cemetery or crematory Zion United Evang. Location Odonnell St.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 SEP 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1944 at 9A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug. 9 1944 to Sept. 7 1944 and that I last saw h[illegible] alive on Sept. 7 1944

Immediate cause of death Coronary Thrombosis — Duration acute
Due to Coronary Heart Disease — 1 mo
Due to Hypertension — 7
Other Conditions Obesity

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Frances Reitz
Address 2012 E. Baltimore St Date signed 9/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20595

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G20595 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 North Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 North Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Michael Carrington

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/9/43

8. AGE: Years | Months 11/10 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Alfred Carrington
13. Birthplace Md

MOTHER 14. Maiden Name Edmonya Dupas
15. Birthplace Md

16 (a) Informant Alfred Carrington
(b) Address 1116 Stricker St

17 (a) Burial (b) Date thereof 9/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Guy H. Kelso
(b) Address 1303 Preastman

19 (a) (b)
(Date rec'd by local reg.) SEP 8 - 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7, 1944 at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infantile Diarrhea

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 7 1944

G20596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1119a

G20596 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City, town, or location Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Laurens St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Hall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: S
6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26, 1944

8. AGE: Years | Months: 1 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Balto. Md
(Town, county, and state)
10. Usual Occupation: Infant
11. Industry or business

FATHER
12. Name: Lorenzo Hall
13. Birthplace: Va

MOTHER
14. Maiden Name: Sarah Calhoun
15. Birthplace: Va

16 (a) Informant: Lorenzo Hall
(b) Address: 1708 Laurens St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory: Mt Auburn
Location: Md.

18 (a) Funeral director: Leo. G. Kelson
(b) Address: 1303 Pennsylvania Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 11 SEP 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1944 at 7:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from September 2 1944 to Sept. 6 1944, and that I last saw him alive on Sept 6 1944.

Immediate cause of death: Acute heart intermittin

Due to

Due to

Other Conditions: Malnutrition

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: G. N. Banfield, M.D.
Address: Provident Hospital Date signed 9/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20597

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G20597 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: S. E. Corner Charles & Franklin Sts.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Keys Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
About 62			hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Ladies Lady

11. Industry or business Silverware & Jewelry

FATHER
12. Name John H. B. Young
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Brooks
15. Birthplace Maryland

16 (a) Informant Cyrus E. Young Jr.
(b) Address Princeton, New Jersey

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore, Maryland

18 (a) Funeral director H. N. Mears & Son
(b) Address 805 N. Calvert St.

19 SEP 8 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1944, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH (a) Coronary Occlusion
(b)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallace Medical Examiner. M.D.
Date signed Sept. 7, 1944.

PRINTED WHITE PENCIL, Wood UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No. G20598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town.)
(d) Street No. 411 W. Monument St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Allen Gilson

3 (b) If veteran, name war

3 (c) Social Security Account No. 214144363

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation daysworks

11. Industry or business

FATHER 12. Name Robert Mason

13. Birthplace Washington D.C.

MOTHER 14. Maiden Name Lena Johnson

15. Birthplace Va.

16 (a) Informant Mrs. Dorsey

(b) Address 411 Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-44 (month) (day) (year)

(c) Cemetery or crematory
Location Wash. D.C.

18 (a) Funeral director A. Halstead

(b) Address 968 Druid Hill Ave

19 (a) SEP 8 - 1944 (Date rec'd by registrar) (b) Hunting for Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1944, at 11:30 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Valvular heart disease, aortic, syphilitic.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature J. L. Wallenmeyer M.D. Medical Examiner.

Date signed Sept. 11, 1944

VS 151

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DOROTNY E. KENDLE ✓

G20599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

102

Registered No. G20599

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mt. Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. Potomac St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Dorothy E. Kendle

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jack M. Kendle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16-1923

8. AGE: Years 21 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name John Wilbur Jacobs

13. Birthplace Baltimore Md.

MOTHER 14. Maiden Name Emma Baker

15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Jacobs

(b) Address 1211 Wilson Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11-1944 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore, Maryland

18 (a) Funeral director Burgee Funeral Home

(b) Address 2631 Falls Road

SEP 8 - 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/7 19 44 6:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 19 44 to 9/7 19 44

and that I last saw h alive on 9/7 19 44

Immediate cause of death Cerebral Hemorrhage | Duration

Due to Malignant Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature J. Carl Myers, M.D.

Address Mt. Sinai Hosp. Date signed 9/7/44

G20600

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95a

G20600 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 E Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 E. Belvedere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard P. Skinner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ethel L

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 13 1876

8. AGE: Years 67 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired B&O RR

11. Industry or business

FATHER 12. Name Thomas Skinner
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Katherine H Jarvis
15. Birthplace England

16 (a) Informant Ethel L Skinner
(b) Address 308 E Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet Cem
Location Frederick Road

18 (a) Funeral director John G Regan
(b) Address 3000 E Baltimore St

19 (a) SEP 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1944, at 1150P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 20 1937, to 9-6 1944, and that I last saw him alive on Sept 4 1944.

Immediate cause of death Hypostatic Pneumonia — Duration Sept 4 to 6

Due to Auricular Fibrillation — Aug 7 1944

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elbert Roberts M. D.

Address 6100 York Road Balto Md Date signed 9/6/44

G20601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

182a

Registered No. G20601

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 619 Harvey Street
(c) Hospital or institution: 24

(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Harvey Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter C. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 7 1944

8. AGE: Years	Months	Days	If less than one day
-	2	-	hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name Raymond Brown.
13. Birthplace Balto.

MOTHER 14. Maiden Name Gertrude Hengsbaugh
15. Birthplace Balto.

16 (a) Informant Family
(b) Address 619 Harvey St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-9-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Baltimore Highway

18 (a) Funeral director James L. McCully
(b) Address 50 E. Hamilton Ave.

19 SEP 8 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 19 44, at 5:40 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation due to bedclothes

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-7-44 at 5 A. M.
(b) Where did injury occur? 619 Harvey Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury Smothered in bedclothes

23. Signature H. Lee Dallenmyer M.D.
Medical Examiner.
Date signed Sept. 7, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12/a

✓ G20602 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 705 Pierce St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 Pierce (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Carter Brooks.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1895

8. AGE: Years 49 | Months - | Days - | If less than one day hr. min.

9. Birthplace Cape Charles Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Gustus Brooks

13. Birthplace Virginia

MOTHER 14. Maiden Name Georgiana Church

15. Birthplace Virginia

16 (a) Informant Willie Brooks

(b) Address 1304 W Lanvale St

17 (a) Burial (burial, cremation, or removal) (b) Date thereof Sept 8 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem

Location Balto. Md

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N. Schroeder St

19 (a) (Date received by registrar) SEP 8 - 1944 (b) Huntington Williams, M.D.

VS-150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 4 1944, at 9 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Sept 4 1944 and that I last saw h[illegible] alive on Sept 3 1944.

Immediate cause of death Uraemia
Cerebral Hemorrhage
Due to Arteriosclerosis
Due to Myocarditis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
4 Days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Edmund Chandler M. D.
Address 422 W Lee St Date signed 9/9/44

G20603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$3a

G20603 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 243 South Regester St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) 42

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-31, (If outside city or town limits, write RURAL and give town)
(d) Street No. 243 South Regester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Matilda Ratajczak-(Or) Growtilda Ratajczak.

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband ~~or wife~~ Henry Ratajczak

6 (c) If alive, give ~~address~~ Deceased

7. Birth date of deceased (mo., day, yr.) 1871 ?

8. AGE: Years 73 ? | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name ? Wendziekowski
13. Birthplace Unknown

MOTHER: 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Adam Soboczynski (Son)
(b) Address 243 South Regester Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-44 (month) (day) (year)
(c) Cemetery or crematory ST. STANISLAUS
Location Baltimore md.

18 (a) Funeral director George A Weber
(b) Address 795 S Ann st

19 (a) SEP 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 1944, at 2.25 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1944 to Sept 8 1944 and that I last saw ~~him~~ her alive on Sept 7 1944

Immediate cause of death: Cerebral Hemorrhage (Cerebrovascular?) — Duration: 2 days

Due to: Cerebral arterio Sclerosis — Duration: ?

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 2007 E Fratt Date signed 9/7/44

VS 160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G20604

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Aisquith
(c) Hospital or institution:
Institution of Notre Dame
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Aisquith (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sr. M. Friedeline Rondthaler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV 25 1892

8. AGE: Years	Months	Days	If less than one day
51 52	9	10 17	hr. min.

9. Birthplace Pittsburgh Pa
(Town, county, and state)

10. Usual Occupation Teacher

11. Industry or business Religious

FATHER
12. Name Charles Rhode
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wertner
15. Birthplace Germany

16 (a) Informant Sr. M. Stanislaus Hanke
(b) Address 901 Aisquith Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9/44 (month) (day) (year)
(c) Cemetery or crematory Notch Cliff
Location Glen Arm

18 (a) Funeral director Geo. M. Fenkhorn
(b) Address 811 N Wolfe St

19 SEP 8 1944 (Date rec'd by Reg.) (b) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1944, at 11.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from February 1944 to Sept. 7 1944, and that I last saw her alive on Sept. 7 1944.

Immediate cause of death	Duration
Uremia Sclerosis	
Due to hypertension	
Due to Cerebral Hemorrhage	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. J. Hurley Coroner

Address 110 E North Ave Date signed 9/9/44

G20605

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20605 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.0.4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2440 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Earnest ~~William Cornish~~ William Cornish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Nellie Cornish

6 (c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): 11-4-98

8. AGE: Years 52 | Months 5 10 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Janitor

11. Industry or business: Balto. City Schools

FATHER
12. Name: John Cornish
13. Birthplace: Md.

MOTHER
14. Maiden Name: Georgianna Cornish
15. Birthplace: Md.

16 (a) Informant: Nellie Cornish (Wife)
(b) Address: 2440 Druidhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 10, 1944 (month) (day) (year)
(c) Cemetery or crematory: Mount Auburn
Location: Baltimore, Md.

18 (a) Funeral director: Charles R. Lear
(b) 1944 802 Madison Avenue

19 (a) ____ (Date rec'd by registrar) (b) ____ Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 7, 19 44, at 10:05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Aneurysm of descending aorta, syphilitic

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. W. Wallamsmeyer M.D.
Medical Examiner.
Date signed Sept 7, 1944.

Huntington Williams, M.D. Registrar

Please write plainly, with UNFADING INK. Every item or information should be carefully checked and correct. Care is especially important. Physicians: please write the causes of death clearly and legibly.

G20606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G20606 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 Patapsco Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A A county
(c) City or town Clearwater Beach Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. House #6 (If rural give location)
(e) Citizen of foreign country? ---- (Yes or No)
If yes, name country

3 (a) FULL NAME Godfrey Fischbach

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~XXXXXX~~ or wife Elizabeth Fischbach

6 (c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) January 3,1878

8. AGE: Years 66 | Months 9 - | Days 3 - | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Retired Salesman

11. Industry or busine Middleman & Wise Tobacco Co.

FATHER
12. Name Detris Fischbach
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Pfeiffer
15. Birthplace Germany

16 (a) Informant Mrs. Margaret Vanskiver
(b) Address Clearwater Beach Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept9-44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Cemetery
Location Elkridge Md.

18 (a) Funeral director Milton Schilling
(b) Address 3914 S Hanover St Suite 25

SEP 8 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6, 1944, at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-10 19[illegible] to Sept 6 1944, and that I last saw h[illegible] alive on Sept 6 1944.

Immediate cause of death Acute Coronary Occlusion — Duration 15 Min.

Due to Arteriosclerosis

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

M.D. Signature Paul Ludlam

Address 320 Outingwood Ave Date signed 9/8/44

G20607

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G20607

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 235 S. Fremont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 235 S. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G. newhouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 8 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1944, at 3 60 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
cardiovascular
Due to disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Act Medical Examiner.
Date signed 9-[illegible]

2139

PRINT WITH PENCIL, WITH UNFADING INK. Every item or information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G20608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Walbrook & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Baltimore Brooklyn Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Riverside Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-44

8. AGE: Years	Months	Days	If less than one day
			12 hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William
13. Birthplace Md

MOTHER 14. Maiden Name Agnes Fisher
15. Birthplace Md.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 8 1944 for Williams Registrar
(Date rec'd by registrar)

VS 180

2140

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1944 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 19XX to 9/2 19XX and that I last saw ~~her~~ alive on 9/2 19XX

Immediate cause of death Premature

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. I. Rafferee M. D.
Address St. Agnes Hospital Date signed 9/7/44

G20609

a 37309

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20609

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or Institution: JOHN HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne arundel
(c) City or town [redacted] Parole
(If outside city or town limits, write RURAL and give town)
(d) Street No. Meredith Heights
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rice

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Black	Infant

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			3 hr. 3 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. Rice
13. Birthplace

MOTHER
14. Maiden Name Viola
15. Birthplace

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 8 1944

18 (a) Funeral director Commissioner of Health.
(b) Address

19 SEP 8 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1- 1944, at 2 07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1- 1944 to 9-1- 1944, and that I last saw h[illegible] alive on 9-1- 1944

Immediate cause of death Respiratory failure — Duration
Due to prematurity — 3hrs
Due to
Other Conditions Atelectasis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Jarl Koenig M. D.
Address Johns Hopkins Hosp. Date signed 7-4-45

2141

G20610

BALTIMORE CITY HEALTH DEPARTMENT V G20610 Registered No.

CERTIFICATE OF DEATH 47a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. No correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2624 Hudson St.
(c) Hospital or institution (If not in hospital or institution, give residence)
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(c) Street No. 2624 Hudson St. (If rural give location)
(d) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas M. Matusek (Matsak)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Justina August

(b) Address 2624 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 9, 1944 (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Cem. Location Dundalk Ave.

18 (a) Funeral director John F. Rudd

(b) Address 3829 Hudson St

19 (a) Filed Sep 9 1944 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1944, at 7 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 7 1944, and that I last saw him alive on Sept 6 1944.

Immediate cause of death Cerebrovascular C. V. Disease

Coronary Occlusion

Due to Myocardial Failure

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

Duration
9-7-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence None at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature E. Schumacher M. D.

Address 842 E. Eastern Ave. Date signed 9-8-44

Clyde Williams, M.D.

G20611 TH. 89675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G20611

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 Washington Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Lewis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband ~~or wife~~ Howard W. Lewis's
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21. 1890

8. AGE: Years 54 | Months ? | Days 15 | If less than one day hr. min.

9. Birthplace Wash. D. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name James Becraft
13. Birthplace ?

MOTHER 14. Maiden Name Annie Phelps
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-44 (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Woodbine Carroll Co. Md.

18 (a) Funeral director C. M. Wall
(b) Address Winfield Md

19 (a) SEP 8 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6-44 19 , at 3.20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 19 44 to 9-6 19 44 and that I last saw her alive on 9-6 19 44.

Immediate cause of death Carcinoma of Cervix — Duration 1½ yrs

Due to

Due to

Other Conditions Secondary Anemia Cachexia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hawk E. Dalton M. D.
Address Balt. City Hosp Date signed 9/6/44

G20612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20612 ✓ 83a

Registered No. G20612

Every item of information should be carefully written. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be answered or the word "unknown" or the correct word inserted. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 51
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5-0A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 N. Fremont Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Shines

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 26 1910

8. AGE: Years	Months	Days	If less than one day
34	2	11	hr. min.

9. Birthplace Dunn, N. C.
(Town, county, and state)

10. Usual Occupation Defense Worker

11. Industry or business

FATHER
12. Name David A. Smith
13. Birthplace Dunn, N. C

MOTHER
14. Maiden Name Anna Autheud
15. Birthplace N. C.

16 (a) Informant David A. Smith
(b) Address 1414 E Lombard St

17 (a) Burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Eden Terrace, Baltimore, Md.

SEP 8 - 1944

19 (a) (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6- 1944, at 8 45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to last death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Subarachnoid Hemorrhage

Due to

Other Conditions Intraventricular Hemorrhage.

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Mullen M.D.
Medical Examiner.

Date signed 9-6-44

JL - G20613

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20613

CERTIFICATE OF DEATH 13a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 3 - 28
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1357 Carroll St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME m Annie Anderson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Sep.

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1882

8. AGE: Years	Months	Days	If less than one day
62	6	12	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation House work
11. Industry or business

FATHER
12. Name John Johnson
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah Foote
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Thos O. Wilson
(b) Address 1000 Bentley Ave
SEP 8 - 1944 Washington Williams
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5-44 19 , at 1:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7 19 43, to 9-5 19 44, and that I last saw her alive on 9-5 19 44.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to	
Due to	
Other Conditions Hypertensive C V disease Chronic nephritis	2 yrs

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Kenneth Smith M. D.
Address Balt. City Hosp Date signed 9/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

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G20614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

✓ G20614 Registered No.

Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PENCIL, WRITE ONE LETTER IN A SQUARE. USE BLACK INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1753 Orleans Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John R. Hopkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Anna May Hopkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22 1908

8. AGE: Years	Months	Days	If less than one day
36	4	15	hr. min.

9. Birthplace Rosell N. J.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Lewis Hopkins
13. Birthplace N. J.

MOTHER
14. Maiden Name Josephine Jackson
15. Birthplace Va.

16 (a) Informant Anna May Hopkins
(b) Address 1753 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-44 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Elizabeth, N. J.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Braddish Ave

19 (d) SEP 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1944, at 12:05 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bronchial Asthma.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. W. Wollenmeber M.D. Medical Examiner.
Date signed Sept. 7, 1944.

G20615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20615 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 402 Woodlawn Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State N. Y. (b) County Wayne
(c) City or town Walworth
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE L. CARTER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Osmon Olin Carter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1857

8. AGE: Years	Months	Days	If less than one day
86	9	9	hr. min.

9. Birthplace Walworth, Wayne Co., N. Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Frederick Bean
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea Louisa Kline
15. Birthplace Germany

16 (a) Informant Commander F.LO Peacock
(b) Address 402 Woodlawn Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/8/44 (month) (day) (year)
(c) Cemetery or crematory Walworth Cem.
Location Walworth, N. Y.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 8 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27 1944, to Sept 8 1944, and that I last saw her alive on Sept 8 1944.

Immediate cause of death: Uremic Coma — Duration: 2 days.
Due to: Hypertension Chronic Nephritis Arteriosclerosis — ?
Other Conditions: Infirmity Old age
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. V. Meyer Jr.
Address 1520 E. 33rd St. Date signed 9/8/44 (M. D.)

C20616 AB-89321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. C20616

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave. 10-1
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1134 Homewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Reely

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8-1872

8. AGE: Years 71 | Months 10 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Charles Reely
13. Birthplace Md.

MOTHER
14. Maiden Name Henrietta Nicholson
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Forestville Md.

18 (a) Funeral director Williams Funeral Home Inc.
(b) Address 2174 Pennsylvania Ave.

19 (a) SEP 9 1944 (b) Huntington Williams, M.D.

VE 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-6- 1944, at 11.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-8- 1944, to 9-6 1944, and that I last saw him alive on 9-7 1944.

Immediate cause of death Senile
secondary anemia; inanition
Due to Ca of stomach
Due to
Other Conditions Gen. arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seyman M.D.
Address BCH Date signed 9/8

G20617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

Registered No. G20617

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 830 W. Pratt st
(c) Hospital or institution:

18-3

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 830 W. Pratt st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith L. Chaffman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced:
Female	White	Married

6 (b) Name of husband ~~or wife~~ Louis Chaffman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9th 1890

8. AGE: Years	Months	Days	If less than one day
53	11	28	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Wilbur Rutter
13. Birthplace Md.

MOTHER
14. Maiden Name Martha V. Hennicks
15. Birthplace Md.

16 (a) Informant Thelma Hall
(b) Address 830 W. Pratt st.

17 (a) Burial (b) Date thereof 9/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery Meadowridge Mem
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 SEP 9 - 1944 (b) Hunting for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7th 1944 at 2 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944, to Sept 7 1944, and that I last saw h[illegible] alive on Sept 7 1944.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to Rheumatic Fever

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Year

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 801 Arrington Date signed 9 | 8 | 44
(M) (D) (Y)

G20618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20618 Registered No. 12B

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 N. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3. (a) FULL NAME Wm. A Frazier Rev. John A. (Matthews) ~~Forgot~~

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace Howard Co., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Frank Matthews
13. Birthplace Howard Co. West Friend Md.

MOTHER
14. Maiden Name Sally Bonds
15. Birthplace Howard Co. Md

16 (a) Informant Wm. H. Matthews
(b) Address 705 N. Bruce St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Nat. Cem.
Location Balto.

18 (a) Funeral director Chas. H. Langenderfer
(b) Address 927 No Mount St.

19 (a) Sept 9 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6, 1944, at 12:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Tuberculosis, pulmonary

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollenweber M.D. (Medical Examiner.)
Date signed Sept. 7, 1944.

G20619
AB-89689

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20619
Registered No. 94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 E. Foster Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hosea M. Dinsmore

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21-1874

8. AGE: Years	Months	Days	If less than one day
70	7	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

FATHER
12. Name Robert Dinsmore
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Armstrong
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremation (b) Date thereof 9/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Crem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received (b) Registrar
SEP 9 1944
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1944, at 6.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1944, to 9-7 1944, and that I last saw h im alive on 9-7 1944.

Immediate cause of death	Duration
Coronary artery thrombosis	12 hrs.
Due to Coronary arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: was not

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith M. D.
Address Balt. City Hosp Date signed 9/9/44

G20620
AB-89628

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20620
Registered No.

1469

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Greenwillow St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 6-1906

8. AGE: Years 37 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Young
13. Birthplace Md.

MOTHER
14. Maiden Name Emma White
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address , Records

17 (a) Burial (b) Date thereof 9-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cemetery
Location Cedar Hill Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) (Signature of registrar) (b) Huntingtown Williamsport, Md.
SEP 9 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 7 1944, at 1.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1944, to 9-7 1944, and that I last saw him alive on 9-7 1944

Immediate cause of death: Acute pancreatitis intestinal obstruction (paralytic ileus?); peritonitis — Duration ?
Due to carcinoma of head of pancreas
Due to
Other Conditions cirrhosis liver
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(d) Means of injury
23. Signature C. Kelly, Jr. M. D.
Address City Hosp. Date signed 9-8-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct as is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20621

AB-89442

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 153

Registered No. G20621

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1021 Hewitt Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Hubbard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 2-1944

8. AGE: Years	Months	Days	If less than one day
	1	6	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Windell Hubbard
13. Birthplace ?

MOTHER
14. Maiden Name Ruby Cantrell
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 '44 (month) (day) (year)

(c) Cemetery or crematory Loyola Va
Location

18 (a) Funeral director Hermann & Son
(b) Address 32 S. Broadway

19 (a) (Date received by registrar) SEP 9 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8- 1944, at 11.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18- 1944, to 9-8 1944, and that I last saw her alive on 9-8- 1944.

Immediate cause of death Terminal pneumonia — Duration 12 days

Due to Epidermolysis, bullosa hereditaria — 1 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Kenneth Smith
Address Balt. City Hosp. Date signed 9/9/44 D

G20622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20622 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 - 1 - 14
(e) Length of stay in Baltimore (yrs., mos., or days) 21 - 1 - 14

2. USUAL RESIDENCE OF DECEASED:
(a) State N. J. (b) County
(c) City or town Trenton (If outside city or town limits, write RURAL and give town)
(d) Street No. 332 East State Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1880

8. AGE: Years 64 | Months 2 | Days 23 | If less than one day hr. min.

9. Birthplace New York City (town, county, and state)

10. Usual Occupation Surveyor

11. Industry or business

FATHER
12. Name John Williams
13. Birthplace Trenton, New Jersey

MOTHER
14. Maiden Name Mary Barker
15. Birthplace New York City

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-11-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore

18 (a) Funeral director Stewart & Maguire Co.
(b) Address 108 W. Madison

19 (a) SEP 9 1944 (b) Registrar Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8, 1944, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 19 34, to Sept. 8 1944, and that I last saw h. alive on Sept. 8, 1944.

Immediate cause of death — Duration
Repeated Myocardial infarct — 7 days
Due to Arterio Sclerosis — 5 yrs.
Due to
Other Conditions Lower Extremities Dead — 2 1/2 yrs.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Dewey D. Magee M. D.
Address 23 N. Eutaw St.

G20623

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93

Registered No. G20623

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5711 Belair Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Cole

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary F. Cole

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20th 1897

8. AGE: Years 47 | Months 1 | Days 18 | If less than one day hr. min.

9. Birthplace Balto. City Md. (Town, county, and state)

10. Usual Occupation Roofer

11. Industry or business Roofing

FATHER
12. Name John H. Cole
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Lilly McGann
15. Birthplace

16 (a) Informant: Mrs. J. H. Cole
(b) Address 5711 Belair Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 8 11 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. City Md.

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Rd.

19 (a) SEP 9 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

55

20. DATE OF DEATH September 7, 1944 at 12 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diffuse myocardial fibrosis

Cardiac hypertrophy, marked

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Sept 8 1944

V8 181

Every item or information should be carefully supplied. Use UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20624

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20624
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 222 S. Gilmor St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 222 S. Gilmor St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Farber

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Lehman Farber
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 29-1877

8. AGE: Years 68 | Months 10 | Days 6 10 | If less than one day hr. min.

9. Birthplace Chambersburg Pa (Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Charles Cunningham
13. Birthplace Pa.

MOTHER
14. Maiden Name —
15. Birthplace Pa

16 (a) Informant Oscar F. Farber
(b) Address 222 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. D. Heptinstall & Son
(b) Address 1300 Eutaw Place

19 SEP 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 1944, at 2.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1944, to Sept 8 1944, and that I last saw — alive on Sept 7 1944.

Immediate cause of death Cardiac failure — Duration

Due to Coronary artery disease

Due to Generalized Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Sborofsky MD
Address 601 N. Monroe St Date signed 9/9/44

G20625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20625
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts.
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore - Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 243 Jappe Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Edward Dunn

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Balto - Md
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Dunn
13. Birthplace Md

MOTHER
14. Maiden Name Marie H. Gray
15. Birthplace Ky

16 (a) Informant Edward. Dunn
(b) Address 243 Jappe Road
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.
18 (a) Funeral director F. S. Wentzel Sons
(b) Address 300 Eutaw Place
19 (a) SEP 9 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8-44 19 , at 6:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-44 19 , to 9-8-44 19 , and that I last saw him alive on 9-8-44 19 .

Immediate cause of death Asphyxiation

Duration

Due to

Due to

Other Conditions Coronary Occlusion Heart
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Clyde Webster, M.D.
Address Franklin Sq. Hosp. Date signed 9/8/44

G20626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G20626

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... applied. correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1716 Patapsco St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 - 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1716 Patapsco St. (Formerly 1717 Patapsco St. Extended) (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert B. Zogler

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-10-4202

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife (Ona Heckrotte) Sarah E. Zogler
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1872

8. AGE: Years	Months	Days	If less than one day
72	7	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Day Laborer
11. Industry or business Sewer Pipe & Stevedore Co.

FATHER
12. Name Robert Zogler
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md.

16 (a) Informant Geo. E. Zogler (Son)
(b) Address 1716 Patapsco St. Balto 30, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. G. Co., Md.

18 (a) Funeral director C. Howard Evans
(b) Address 1499 S. Charles St. (420)

19 SEP 9 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8, 1944 at 3:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1, 1944 to 9-8-1944 and that I last saw h... alive on 9-8 1944

Immediate cause of death Chronic Myocardial degeneration — Duration 1 yr.
Due to Arteriosclerosis — 2 yrs.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. S. Ballard M. D.
Address 707 E. Fortune Date signed 9-9-44

G20627

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G20627

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto Md
(b) Street address 1103 Dra Kean Ave
(c) Hospital or institution: ✓ 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Dra Kean Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert William Reed

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Margaret Louise
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 54 Aug. 1 | 13 | 1883

8. AGE: Years	Months	Days	If less than one day
61	7	25	hr. ✓ min.

9. Birthplace Falmouth England
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Robert William Reed
13. Birthplace Falmouth Eng

MOTHER
14. Maiden Name Elizabeth Erba
15. Birthplace Falmouth Eng

16 (a) Informant Mary Young Taylor
(b) Address 35 Clifton Ave

17 (a) Burial (b) Date thereof Sept 11 -44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location Edmondson Ave Balto.

18 (a) Funeral director Wachter Brooks Bradley
(b) Address 1934 W North Ave

19 (a) SEP 9 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1944 at 1130 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 8 1944, and that I last saw h[illegible] alive on Sept 8 1944.

Immediate cause of death Bronchopneumonia — Duration 6 days
Due to Cerebral Hemorrhage
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Albert Kennard
Address 1934 Wilkens Ave Date signed 9/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V8 3

G20628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20628 / 136

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2907 Baker St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2907 Baker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John G. Hufnagel

3 (b) If veteran, name war —
3 (c) Social Security account No. 217-18-0116

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen Hufnagel
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) March 25-1886

8. AGE: Years 58 | Months 5 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Book Keeper

11. Industry or business

MOTHER / FATHER
12. Name John Hufnagel
13. Birthplace Baltimore Md
14. Maiden Name Hannah Letmate
15. Birthplace Baltimore Md

16 (a) Informant Helen Hufnagel
(b) Address 2907 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md.

18 (a) Funeral director Hynes & Flaherty
(b) Address 1426 Light St.

SEP 9 1944 Date Received Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 1944 at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 15 1944 to Sept 7 1944, and that I last saw him alive on Sept 7 1944.

Immediate cause of death: Coronary occlusion — Duration 7 hrs

Due to: Coronary atherosclerosis

Due to:

Other Conditions: Rheumatic H.D. mitral stenosis + aortic insufficiency (Indicate pregnancy, puerperium, or abortion if contributory or related)

Date of operation: No operations

Major findings of operation:

of autopsy: No autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Richard H. Tillman M. D.
Address 3035 St. Paul St. Date signed Sept 7 44

C20629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

Registered No. C20629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwood & Greene Sts University Hospital

(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17-2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1039 Myrtle Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	B	Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-30-44

8. AGE: Years	Months	Days	If less than one day
		6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Jackson

13. Birthplace S. C.

MOTHER 14. Maiden Name Beatrice Metts

15. Birthplace S. C.

16 (a) Informant Henry Jackson

(b) Address 1039 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 9-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion Cem

Location Balto. Co. Md.

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St

19 (Date received by registrar) SEP 9 - 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1944, to 9-5 1944, and that I last saw her alive on 9-5 1944.

Immediate cause of death Prematurity

DIARRHEA

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 DAYS

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W. D. Lyon M. D.

Address University Hospital Date signed 9-6-44

G20630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G20630

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1420 Carroll Av
(c) Hospital or institution:
DOA. Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Since

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Franklintown Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter F. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18 - 1899

8. AGE: Years	Months	Days	If less than one day
45	3	19	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Fireman Co.

11. Industry or business Engine House Upholstering

FATHER
12. Name — Smith.
13. Birthplace

MOTHER
14. Maiden Name Mary Smith
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Blotine Matthews
(b) Address 1420 Carroll Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mr. Wingus

18 (a) Funeral director Mr. Hattie R. Williams
(b) Address 322 N. Dolphin St.

19 (a) SEP 9 - 1944 Hunting for Williams M.D. Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/6 1944, at 12:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Leigh B. McNulty M.D.
Medical Examiner.
Date signed 9/6/44

G20631

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

Registered No. G20631

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Fremont Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Alice R. Keys

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife Alice R. Keys
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) June 24 1898

8. AGE: Years	Months	Days	If less than one day
46	7	12	....hr. ....min.

9. Birthplace Baltimore Md.
(Town, county and state)
10. Usual Occupation Teacher
11. Industry or business Public School System

FATHER
12. Name Noble Keys
13. Birthplace Md

MOTHER
14. Maiden Name Louisa Smith
15. Birthplace Va

16 (a) Informant Alice R. Keys
(b) Address 822 N. Fremont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location.....

18 (a) Funeral director Robert L. Cowen
(b) Address 804 N. Carrollton Ave.

19 (Date received by registrar) SEP 9 1944 Huntington Willis Medical Examiner

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-5- 1944, at 8 45 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gunshot wound of abdomen

Due to.....

Other Conditions Generalized acute peritonitis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-2-44 at 6.45 P.M.
(b) Where did injury occur? 822 N. Fremont ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - revolver

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 9-6-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20632

G20632 M 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR ENDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Point of Rocks
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Elliott
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of ~~husband~~, or wife Meta Elliott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles M. Elliott
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Compher
15. Birthplace Va.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)
(c) Cemetery or crematory St. Paul's Cem. Point of Rocks, Md.
Location ~~Point of Rocks, Md.~~

18 (a) Funeral director M. R. Peterson & Son
(b) Address Frederick, Md.

19 SEP 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1944, at 6.02 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944 to 9/9 1944, and that I last saw h/Ms alive on 9/7 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Acanthosis Nigricans	
Due to Carcinoma stomach	
Other Conditions Pulmonary infiltration & consolidation	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Gross.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Robert Marks M. D.
Address Univ. Hosp. Date signed 9/9/44 Balto. Md.

(OVER)

G20633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20633

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 QUANTRIL WAY
(c) Hospital or institution:
ARMSTEAD GARDENS.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 QUANTRIL WAY ARMSTEAD
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY POLLOCK

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 9 1944

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name GEORGE POLLOCK
13. Birthplace PENNA.

MOTHER
14. Maiden Name MARY BIGLER
15. Birthplace PENNA

16 (a) Informant GEORGE POLLOCK (FATHER)
(b) Address 920 QUANTRIL WAY ARMSTEAD

17 (a) BURIAL (b) Date thereof SEPT. 9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeiler
(b) Address 403 S. MOLE ST.

19 (a) (Local registrar) (b) Huntington Williams M.D.
Registrar

SEP 10 1944

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 9 1944, at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1944, to Sept 9 1944, and that I last saw h[illegible] alive on Sept 9 1944.

Immediate cause of death: Prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leo M. Baumgartner

Address Balto 6 Md Date signed 9/9/44 M. D.

G20634

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G20634 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1228 S. Hanover St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1228 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walerya (Walera) Stanowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Joseph Stanowski | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1879

8. AGE: Years 65 | Months 6 | Days 23 | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Ignatz Glinka
13. Birthplace Poland

MOTHER
14. Maiden Name Walerya Glinska
15. Birthplace Poland

16 (a) Informant Husband
(b) Address 1228 S. Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Gerynon Hill Road

18 (a) Funeral director John Duda
(b) Address 29 Hadson St

19 (a) 10/1944 (Entered by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 1944 at 7:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1944 to Sept. 7, 1944 and that I last saw h alive on Sept. 7, 1944.

Immediate cause of death Hypertensive Cardio Vascular Disease — Duration Chronic

Due to Diabetes

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Johnson M. D.
Address 1123 St. Paul St Date signed 9/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G20635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ G20635 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3127 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Cora A. Moffett

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 1887

8. AGE: Years	Months	Days	If less than one day
57	4	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Teacher
11. Industry or business

FATHER
12. Name Robert Moffett
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara ? Baldwin
15. Birthplace Maryland Penna

16 (a) Informant Mr. Robert Moffett
(b) Address Chestertown, Md.

17 (a) Burial (b) Date thereof 9/11/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Chester
Location Chestertown, Maryland

18 (a) Funeral director Broyles & Schumacher
(b) Address 2401 Madison Ave.

19 (a) SEP 10 1944 (b) Washington Williams, Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-44 1944 at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 6 1944 to Sept. 9 1944 and that I last saw h alive on Sept 9. 1944.

Immediate cause of death	Duration
Cardio-Respiratory failure	
Due to Stroke - resulting	
Due to operation for Carcinoma of bowel.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-8-44.
Major findings of operation: Metastatic carcinoma splenic flexure
of autopsy: Carcinoma bowel

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Loffler M.D.
Address Union Memorial Hosp. Date signed 9/9/44

STATE OF MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20636 BALTIMORE CITY HEALTH DEPARTMENT G20636
CERTIFICATE OF DEATH 50

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Hewitt Way.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1126 Hewitt Way. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. JULIA - ROBERTS.
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-09-9242
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced MARRIED
6 (b) Name of husband or wife Floyd W.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/7/14
8. AGE: Years 30 yrs. Months 2 Days 1 If less than one day hr. min.
9. Birthplace Needmore, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Harvey Mellott
13. Birthplace Pa.
MOTHER 14. Maiden Name Angeline Lander
15. Birthplace Hancock, Md.
16 (a) Informant Husband
(b) Address above
17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 9/10/44 (month) (day) (year)
(c) Cemetery Piney Grove Cem.
Location Hancock, Md.
18 (a) Funeral director Charles E. Schimmelpfenek
(b) Address 2601 E. Madison Street
19 (a) 10 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH SEPT. 8 1944, at 10 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 1/20 1943, to 9/8 1944 and that I last saw h[illegible] alive on 9/8 1944.

Immediate cause of death	Duration
Respiratory Failure	4 days
Due to Pulmonary Edema	1 day
Due to Cancer of lung secondary to	1 yr.
Other Conditions Breast Cancer	5 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. E. Bentzmase M. D.
Address 1045 Rodman Way Date signed 9/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct cause is especially important. Physicians: please write the causes of death clearly and legibly.

VS 2

330471 G20637

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20637

CERTIFICATE OF DEATH 938

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ga. (b) County
(c) City or town Augusta (If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 Greene St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julius Shapiro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: Rachel Shapiro

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 5-3-73

8. AGE: Years 71 | Months 4 | Days 6 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Meat Market

11. Industry or business

FATHER 12. Name Benj. Shapiro

13. Birthplace ?

MOTHER 14. Maiden Name - ?

15. Birthplace ?

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-9-44 (month) (day) (year)

(c) Cemetery or crematory Columbia, D.C.

Location

18 (a) Funeral director Jack Reiss Inc

(b) Address W. 23 & Balto. St

19 (a) Date received by registrar SEP 11 1944 (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24 1944 to 9-9-1944 and that I last saw him alive on 9-9-1944

Immediate cause of death	Duration
CARDIAC FAILURE	4 days
Due to Hypertensive Cardiovascular Disease & Arteriosclerotic	5-10 yrs
Due to Heart Disease	
Other Conditions Uremia -	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurie Dechant M.D.

Address Johns Hopkins Date signed 9/9/44

G20638 ✓ G20638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Joseph's
(c) Hospital or institution: Caroline St Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4873 Minnesota
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mark Gettings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Viola Gettings

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Oct 25 1888

8. AGE: Years 55 | Months 11/10 | Days 15 | If less than one day hr. min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual Occupation Stub Mill

11. Industry or business

FATHER 12. Name Geo Gettings
13. Birthplace England

MOTHER 14. Maiden Name Dora Knox
15. Birthplace

16 (a) Informant Geo W Gettings
(b) Address Clarksburg W Va

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 9 1944 (month) (day) (year)

(c) Cemetery or crematory Clarksburg W Va
Location Clarksburg W Va

18 (a) Funeral director Wilson Funeral Home
(b) Address 1008 Orleans St

19 (a) (b) (Date filed by registrar) Registrar

SEP 11 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1944 at 605 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1944 to 9/9 1944 and that I last saw him alive on 9/9 1944.

Immediate cause of death Cerebral Vascular Accident — Duration

Due to Marked Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Melvin Farnsworth

Address Joseph Hunt Date signed 9/9/44

G20639

JL - 89177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V/31a

G20639

Registered No.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 11 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1505 Edmondson Ave.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Willie Woodson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Minnie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1900

8. AGE: Years	Months	Days	If less than one day
44	4 2	10	hr. min.

9. Birthplace Va.

(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name David Woodson

13. Birthplace Va.

MOTHER

14. Maiden Name Judy Anderson

15. Birthplace Va.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 9 10 44 (month) (day) (year)

(c) Cemetery or crematory Farmsville Va

Location Virginia

18 (a) Funeral director Rayner Sanders

(b) Address 1412 E. Preston St

SEP 10 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8-44 19 , at 7.55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27 1944, to 9-8 1944, and that I last saw him alive on 9-8 1944.

Immediate cause of death Uremia — Duration 3 days

Due to Arteriolarnephrosclerosis — ?

Due to

Other Conditions Malignant hypertension ? Hypertens. C-Vasc. disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Kenneth Smith M. D.

Address Balto. City Hosp Date signed 9/8/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20640 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please observe the instructions on the back of this card before filling out the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1701 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Amanda Nachman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, (widowed), or divorced: Widow

6 (b) Name of husband or wife: Adolph Nachman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-30-1859

8. AGE: Years 85 | Months 2 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Winchester, Virginia (Town, county, and State)

10. Usual Occupation NONE

11. Industry or business

FATHER 12. Name Gotty Mahlbaum

13. Birthplace Bavaria

MOTHER 14. Maiden Name Josephinetta ?

15. Birthplace Bavaria

16 (a) Informant Mr. M. Schaan

(b) Address Marlborough Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)

(c) Cemetery or crematory Har Sinai

Location Balto. Md.

18 (a) Funeral director David Sondheim & Son

(b) Address 1902 Eutaw Place

19 (a) (Signature of registrar) (b) Registrar

SEP 10 1944

VS 250

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1944 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1944 to 9-9 1944, and that I last saw her alive on 9-9 1944

Immediate cause of death: Cardio-Resp. failure — Duration

Due to: Arteriosclerotic Heart Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Neil C. Andersen, M. D.

Address Union Memorial Hosp. Date signed 9-9-44

G20641 BALTIMORE CITY HEALTH DEPARTMENT G20641

CERTIFICATE OF DEATH 146B Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506-S Rose St
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 y.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 506 S Rose St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Michael Pruchniewski
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife Katherine
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 67 Months Days If less than one day hr. min.
9. Birthplace Polaland (Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name ?
13. Birthplace Poland

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Joseph Falzar
(b) Address 506 S Rose St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)
(c) Cemetery or crematory St Stanislaus
Location Dundalk Ave
18 (a) Funeral director John Nuttall
(b) Address 2809 Hudson St
19. Date received by registrar SEP 10 1944 (b) Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1944 at 7 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944 to Sept 8 1944 and that I last saw h[illegible] alive on 1944
Immediate cause of death Hypostatic Pneumonia — Duration 9/5/44
Due to Carcinoma of Stomach — 3/1944
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William J. Rylander M. D.
Address 901 N Kenwood Ave Date signed Sept 10 44

G20642

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G20642 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct... is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1419 Darley Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Darley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Murphy

3 (b) If veteran, name war: None
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret Murphy
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 1889

8. AGE: Years 54 | Months 11 | Days 27 | If less than one day: hr. 8 min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Bar Tender
11. Industry or business F. M. Moreland Co

FATHER
12. Name Michael J. Murphy
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Mary V. Lucy
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Margaret C. Murphy
(b) Address 1419 Darley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location 3300 Old Frederick Rd

18 (a) Funeral director Elmer W. Conklin & Son
(b) Address 924 E. Eager St

19 (a) SEP 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8th 1944, at 1:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944, to Sept 8 1944, and that I last saw h[illegible] alive on Sept 8 1944

Immediate cause of death	Duration
Edema of Lungs	2 days
Due to Chronic Myocarditis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. Gill Hall M. D.
Address 1631 E North Ave Date signed Sept 9-44

G20643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20643 Registered No. 61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2004 Kennedy Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Ragan

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 213-20-0220

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank P. Ragan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 16. 1885

8. AGE: Years 59 | Months 6 | Days 2927 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Office Work

11. Industry or business Clerk

FATHER 12. Name James J. Kelly

13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Margaret McCabe

15. Birthplace Ireland

16 (a) Informant Mrs. David C. Lenty (Daughter)

(b) Address 2004 Kennedy Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11/44 (month) (day) (year)

(c) Cemetery or crematory Mayr Cathedral Cem.

Location 4300 Old Frederick Rd.

18 (a) Funeral director Elmer W. Conklin & Son

(b) Address 2242 E. Eager St.

19. Date received by registrar Sept 9 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th. 1944 at 12:5 M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1943 to Sept. 8 1944 and that I last saw he alive on 9/7 1944

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Hypertension Pulm-Vasc. Disease. — 3 yr.

Other Conditions: Diabetes Mellitus — 4 yr.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph S. Blum M.D.

Address 1426 E. Preston St. Date signed 9/9/44

JL - 89627 G20644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G20644 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Wilson

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1864

8. AGE: Years 80 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Andrew Wilson
13. Birthplace Md.

MOTHER
14. Maiden Name Susanna Duff
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 11-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1512 Hollins St

19 (a) Sept. 10 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7 1944, at 1:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1944, to 9-7 1944, and that I last saw h[illegible] alive on 9-7 1944.

Immediate cause of death: Lobar Pneumonia — Duration: 5 days
Due to:
Due to:
Other Conditions: Pleurn, Heart disease ? Gen. arteriosclerosis
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: no post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith M.D.
Address Balt. City Hosp. Date signed 9/8/44

G20645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20645 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen. Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 923 E. Fairmount Ave: Salvation Army
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bryant F. Darling

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced. –

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/1889

8. AGE: Years 54 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Long Island, N.Y.
(Town, county, and state)
10. Usual Occupation Window Dresser
11. Industry or business

FATHER
12. Name Bryant F. Darling
13. Birthplace N.Y.

MOTHER
14. Maiden Name Frances M. Jackson
15. Birthplace N.Y.

16 (a) Informant J. Gasch's Sons
(b) Address Bladensburg Md

17 (a) Removal (b) Date thereof Sept 11 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Bladensburg Md
18 (a) Funeral director J. Gasch & Sons
(b) Address Bladensburg Md
19 (a) SEPT 11 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9- 1944, at 8 05 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madison M.D.
Medical Examiner.
Date signed 9-9-44

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20646

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 937

Registered G20646

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Bel Air
(If outside city or town limits, write RURAL and give town)
(d) Street No. 116 S. main st.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Lillie Serenia Esley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife 0
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 14 NOV. 1869

8. AGE: Years	Months	Days	If less than one day
74	9	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Mr. Robert Esley
13. Birthplace Maryland

MOTHER
14. Maiden Name Frances Harward
15. Birthplace Md

16 (a) Informant Miss Annie E. Sheridan
(b) Address 116 S. Main St., Bel Air Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/44 (month) (day) (year)
(c) Cemetery or crematory Trinity
Location Churchville, Md

18 (a) Funeral director Deaver & Foster
(b) Address Bel Air Md

SEP 11 1944 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Sept. 1944 at 11:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8 Sept 1944 to 10 Sept 1944. and that I last saw h. alive on 10 Sept 1944.

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerotic degeneration Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen Mumkell M. D.
Address Union Memorial Hosp Date signed Sept 10/44

G20647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

3 ✓ 131a

G20647 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 E. Eager St.
(c) Hospital or institution: Ic
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State M.d. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 E. Eager St. (If rural give location)
(e) If foreign born, how long in U. S. A.? ..... years

3 (a) FULL NAME Concett. Capriuolo

3 (b) If veteran, name of war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Dominic

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21 1879

8. AGE: Years	Months	Days	If less than one day
65	5	17	..... hr. ..... min.

9. Birthplace 6 Italy (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Rocco Abate
13. Birthplace Italy

MOTHER
14. Maiden Name Rafeale (Unknown)
15. Birthplace Italy

16 (a) Informant Dominic Capriuolo Husband
(b) Address 416 E. Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd & Moravia Ave

18 (a) Funeral director Frank Peifa Nordo
(b) Address 52 N. Morley St

19 SEP 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1944 at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Sept 7 1944, and that I last saw h.e alive on 9/6 1944

Immediate cause of death Cerebral accident, Heart

Due to Cerebro-Vascular renal disease with

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration
1 wk
10 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Tedeschi M.D.
Address 1901 Eutaw Pl Date signed 9/8/44

G20648

BALTIMORE CITY HEALTH DEPARTMENT X ✓ Registered No. G20648

CERTIFICATE OF DEATH 47 c.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since June 19, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since June 19, 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State NY (b) County
(c) City or town Freeport, Long Island, NY
(If outside city or town limits, write RURAL and give town)
(d) Street No. 97 Broadway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY CLINTON JEWELL

3 (b) If veteran, name war: -

3 (c) Social Security Account No. 216-14-0956

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife. Single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/25/1895

8. AGE: Years 49 | Months 6 | Days 12 13 | If less than one day ... hr. ... min.

9. Birthplace Buffalo, New York (Town, county, and state)

10. Usual Occupation Bos'n

11. Industry or business SS Robin Adair-12/19/1943

FATHER
12. Name Charles S. Jewell
13. Birthplace ? Michigan

MOTHER
14. Maiden Name Mary E. Wagner
15. Birthplace Niagara Falls, N.Y.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT.11/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S.WOLFE ST.

SEP 11 1944 (Date received by Registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 8, 1944, at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19, 1944, to Sept. 8, 1944, and that I last saw h im alive on Sept. 8, 1944.

Immediate cause of death: Bronchiogenic carcinoma of the upper lobe of the right lung with extensive multiple metastases. — Duration: Since 12/1943

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature H C Quinn M. D.
Address Baltimore, Md. Date signed 9/8/44

MS-53648

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20649

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20649 Registered No.

CERTIFICATE OF DEATH 74a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catow Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Ambassador Apts (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Reagan

3 (b) If veteran, name war: No

3 (c) Social Security Account No. 216-05-3477

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Married

6 (b) Name of husband or wife Emma

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 13 1873

8. AGE: Years	Months	Days	If less than one day
71	0	27	hr. min.

9. Birthplace Corry Pa. (Town, county, and state)

10. Usual Occupation Chairman of Board

11. Industry or business Locke Insulator Co.

FATHER
12. Name T. F. Reagan
13. Birthplace Ireland

MOTHER
14. Maiden Name Loretta Brown
15. Birthplace Kane Pa.

16 (a) Informant A. Tolan
(b) Address St Agnes Hospital

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)

(c) Cemetery or crematory
Location Albany, N.Y.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) SEP 11 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1944 at 7:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8 1944 to 9-10 1944, and that I last saw him alive on 9-10 1944.

Immediate cause of death	Duration
Acute Myelogenous Leukemia	4 days
Due to	
Due to	
Other Conditions arteriosclerosis.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Mortimer Jr. M. D.
Address 270 E. St Paul St Date signed 9/10/44

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20650 V G20650 Registered No. 195E

G20650

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME NINA MATTHEWS BECK DUER

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Clarence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1884

8. AGE: Years	Months	Days	If less than one day
59	11	27	hr. min.

9. Birthplace Easton, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name George Beck
13. Birthplace Easton Md.

MOTHER 14. Maiden Name Kate Harden
15. Birthplace Easton Md.

16 (a) Informant Mrs. James S. Sloan
(b) Address 103 Deepdeen Rd.

17 (a) Cremation (b) Date thereof Sept. 11, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) SEP 11 1944 (b) Huntington Williams
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1944, at 2 20 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to Explosion of gas stove

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-44 at 2 P M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work?
(d) Means of injury Explosion of gas stove

23. Signature H. L. Wallenmeyer M.D.
for Medical Examiner.
Date signed 9-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

✓ G20651 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & N. Ave
(c) Hospital or institution: St. Agnes Hosp. 169
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Ellamont St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susan Dorethy ~~Bailey~~ Gurd James

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/44

8. AGE: Years	Months	Days	If less than one day
			20 hr. 35 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas H. James Sr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha E. Bunn
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Thomas H. James Jr.
(b) Address 1612 Ellamont St.

17 (a) Burial (b) Date thereof 9/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

19 (a) (Date rec'd by registrar) SEP 11 1944 (b) Arrington Williams, M.D.

VS 16

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1944, at 11:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1944 to 9-9 1944 and that I last saw her alive on 9-9 1944

Immediate cause of death Congenital Heart Disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. E. McGrath M.D. M. D.
Address St. Agnes Hosp Date signed 9-9-44

G20652 ✓ G20652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 Aisquith St
(c) Hospital or institution: 9 A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sam Flatt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Shoe Maker (Self)

11. Industry or business

FATHER
12. Name Abrahayn Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah
15. Birthplace Russia

16 (a) Informant Mrs. Mollie Flatt
(b) Address 1401 Aisquith St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Joe Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams Funeral Home

SEP 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9- 1944, at 6:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1944, to 9/9 1944, and that I last saw him alive on 9/9 1944.

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Arteriosclerotic Cardio-vascular Disease — 1

Other Conditions: Bronchial Asthma — 2

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jacques S. Blum

Address 1206 E Preston St Date signed 9/10/44

G20653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G20653

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6101 Biltmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6101 Biltmore Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Leitelbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Austria

MOTHER
14. Maiden Name
15. Birthplace Austria

16 (a) Informant Jos Leitelbaum
(b) Address 5701 Biltmore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-44 (month) (day) (year)
(c) Cemetery or crematory Otsego Memorial
Location

18 (a) Funeral director Joe Levins Inc
(b) Address 1739 E. Monument St Williams, Md.

19 (a) Date received by Registrar SEP 11 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-44 19 at 6:58 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1944, to Sept 10 1944, and that I last saw her alive on 9/10 1944.

Immediate cause of death ch myocarditis — Duration

Due to ch arter's Sclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Arunah St Date signed 9/12/44

G20654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G20654 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore - 30 (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Leadenhall St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country —

3 (a) FULL NAME Samuel Hall

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) — 1892

8. AGE: Years 52 | Months — | Days — | If less than one day — hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Cook - Cabin
11. Industry or business —

FATHER 12. Name Isaac J. Hall
13. Birthplace Md.

MOTHER 14. Maiden Name Jamie Martin
15. Birthplace Md.

16 (a) Informant Samuel Hall
(b) Address 901 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A. Davis
(b) Address 142 W. Hoffman St

19 (a) SEP 11 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1944 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1944 to 9/10 1944, and that I last saw him alive on 9/9 1944.

	Duration
Immediate cause of death Cardiac failure	2 hrs
Due to Hypertension C-V disease	2 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alfred J. Nelson M.D.
Address University Hospital Date signed 9/10/44

75 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20655

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

Registered No. G20655

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2232 Prentiss Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs a

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2232 Prentiss Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank P. Sanda

3 (b) If veteran, name war: --
3 (c) Social Security Account No. 218-09-8415

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Josephine Sanda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1885

8. AGE: Years	Months	Days	If less than one day
59	1		hr. min.

9. Birthplace New York
(Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Sun Cab Co.

FATHER
12. Name John P. Sanda
13. Birthplace Europe

MOTHER
14. Maiden Name Unknown
15. Birthplace 2

16 (a) Informant Mrs. Josephine Sanda
(b) Address 2232 Prentiss Place

17 (a) Burial (b) Date thereof Sept. 12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 (a) Filed SEP 11 1944 (b) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th/44 19 , at 12 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Sept 8 1944 and that I last saw h[illegible] alive on Sept 8 1944.

Immediate cause of death	Duration
Due to Uraemia a.	9/4/44
Due to Ch. Bronchopneumonia Nephritis	9/42
Other Conditions Contributory	9/42

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William J. Rosario M. D.
Address 801 N Kenwood Ave Date signed 9/10/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20656 — Registered No. G20656

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 W. Lefington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimo
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1700 W Lefington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Mayden

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	Married

6 (b) Name of husband or wife Josephine Mayden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years	Months	Days	If less than one day
65	—	.	hr. min.

9. Birthplace Richmond Co. Va.
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Richard Mayden
13. Birthplace Va

MOTHER
14. Maiden Name Catherine Brown
15. Birthplace Va.

16 (a) Informant Burl Posey
(b) Address 1,700 - W. Lefington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)
(c) Cemetery or crematory Richmond Co. Va.
Location

18 (a) Funeral director Chas Alexander
(b) Address 922 N. Fremont Ave.

19 (a) (b)
SEP 11 1944 Registrar for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1944 at 8 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 9 1944 and that I last saw h[illegible] alive on Sept 9 1944.

Immediate cause of death	Duration
(a) Acute Cardiac Renal	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature B D Hatcher M.D.
Address 1755 Park Ave Date signed 9/11/44

G20657 Julia Wallace G20657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1126 Dorn Dr DORN
(c) ~~Hospital or institution:~~
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No 1126 Dorn Dr
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Wallace
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. —
4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1910
8. AGE: Years 34 Months Days If less than one day hr. min.
9. Birthplace Hanover Pa
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Private
FATHER 12. Name Richard Hubbard
13. Birthplace Pa
MOTHER 14. Maiden Name Charity Forney
15. Birthplace Pa
16 (a) Informant Mary Madden
(b) Address 1333 Carey
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 13 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
SEP 11 1944 Date received by Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8/44 19 8:30 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 9/4/44 to 9/8/44
and that I last saw h[illegible] alive on 9/4/44
Immediate cause of death: (a) [illegible] Duration
(b) CERVIX
Due to
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature A. Cn. Ellis M. D.
Address 4716 York Rd Date 9/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR PENDING

VS 150

G20658
AB-89668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

950

Registered No. G20658

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Druid Hill Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Della Parker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col.	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20-1881

8. AGE: Years	Months	Days	If less than one day
62	8	18	hr. min.

9. Birthplace N.C.
(Town, county, and state)
10. Usual Occupation Maid (Mt. Royal Hotel)
11. Industry or business

FATHER
12. Name Clay Parker
13. Birthplace N.C.

MOTHER
14. Maiden Name Harriett ?
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (b) Date thereof 9-11-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

19 (a) SEP 11 1944 Huntington Williams, M.D.
(Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 8----- 19 44, at 6.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5- 1944, to 9-8- 1944, and that I last saw h.er alive on 9-8- 1944.

Immediate cause of death sub-acute bacterial endocarditis & septemia (Strep) Duration 3 wks ?

Due to Rheumatic heart disease

Due to

Other Conditions Uremia; infectious arthritis (Strep)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Perry, Jr. M. D.
Address City Hosp. Date signed 9-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G20659 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1634 Gwyns Falls Parkway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 64
(e) Length of stay in Baltimore (yrs., mos., or days) 41yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1634 Gwyns Falls Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha R. Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Morris L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Nathan Fisher
13. Birthplace Russia

MOTHER
14. Maiden Name Faga Rose ?
15. Birthplace Russia

16 (a) Informant Melvin L. Fine
(b) Address 1634 Gwyns Falls Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Washington Road
Location Washington Blvd

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) Date received by registrar SEP 11 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1944, at 3:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to Sept 10 1944, and that I last saw h[illegible] alive on Sept. 9 1944.

Immediate cause of death: Cerebral hemorrhage
Due to: Arteriosclerosis.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature W. E. Needle
Address 2314 - 20 North Ave Date signed 9/10/44

(over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G20660 ✓ G20660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170C

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 W. 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME NANCY POSSIDENTE

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26th 1928

8. AGE: Years	Months	Days	If less than one day
16	0	15	hr. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Student
11. Industry or business

FATHER
12. Name John Possidente
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Linardi
15. Birthplace N. Y.

16 (a) Informant John Possidente
(b) Address 422 W. 23rd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St.

19 (a) Filed by registrar Huntington Williams, M.D. SEP 11 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9th 1944, at 9P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-44 at 9P. M. 11/2
(b) Where did injury occur? Howard St near
(c) Did injury occur at home, on farm, industrial place, in public place? In hotel While at work?
(d) Means of injury pedestrian struck by auto

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 9-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20661

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G20661 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Prentiss Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Jenkins

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Ellen M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7. 1862

8. AGE: Years 82 | Months 8 | Days 1 2 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Concrete Worker

11. Industry or business Balto. City. Retired

FATHER
12. Name John E Jenkins
13. Birthplace Md

MOTHER
14. Maiden Name Mary E. ERDMAN
15. Birthplace Md

16 (a) Informant Mrs Ellen M Jenkins
(b) Address 2205 Prentiss Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Balto.

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

19 (a) SEP 11 1944 (Date received by registrar) (b) Huntington Wilt Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/44 1944, at 7 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Thos. H. McNally M.D. Medical Examiner.
Date signed 9/9/44.

Dr Ogden 2701 N. Calvert st Be 9573

G20662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20662 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARION RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3700 Kimble Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3700 Kimble Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Kenneth E. Burns

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mildred W.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 25th 1900

8. AGE: Years: 44 | Months: 5 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Balto. Co. Md.
(Town, county, and state)

10. Usual Occupation: Vice President

11. Industry or business: Talbott Motors

FATHER
12. Name: Edgar Burns
13. Birthplace: Md.

MOTHER
14. Maiden Name: Virginia Thomas
15. Birthplace: Md.

16 (a) Informant: Mildred W. Burns
(b) Address: 3700 Kimble Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Parkville Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St.

19 (a) (Date received by registrar) (b) SEP 11 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9th 1944, at 3 30/60 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1944, to Sept. 7, 1944, and that I last saw him alive on Sept. 7, 1944.

Immediate cause of death	Duration
Coronary Occlusion	Immediate
Due to ?	
Due to ?	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury

23. Signature Frank N. Ogden. M. D.
Address 2701 N. Calvert. Date signed Sept. 11,

Huntington Williams, M.D.

or Richardson 112 7/20 G20663

G20663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 East 32nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George J Stonsel

3 (b) If veteran, name war W | 3 (c) Social Security Account No. none

4 Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Aug 31. 1811

6 (c) If alive, give age 187[illegible] years

7. Birth date of deceased (mo., day, yr.) Aug 31. 1877

8. AGE: Years	Months	Days	If less than one day
74 77	3	10	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name John Stonsel

13. Birthplace Germany

MOTHER 14. Maiden Name Anna (Markstrum)

15. Birthplace Germany

16 (a) Informant John Stonsel

(b) Address 1717 E 32nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore Md

18 (a) Funeral director Mahoney & Bro

(b) Address 2317 E Pratt St

19 (a) SEP 11 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1944, at 6 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 6 1944 to Sept 10 1944 and that I last saw him alive on Sept 10 1944

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions Cystoscopy Study of Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: Study

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature R E Richardson M.D.

Address 1112 W. 25th St Date signed Sept 11 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

(over)

G20664

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G20664 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 3804 – 8th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 – 8th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence K. Daley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife John W. Daley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9-1869

8. AGE: Years	Months	Days	If less than one day
74	10		hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Ezra Yingling
13. Birthplace Md.

MOTHER
14. Maiden Name Ann Marshall
15. Birthplace Md.

16 (a) Informant Katherine Conaro
(b) Address 3804 – 8th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12-44 (month) (day) (year)
(c) Cemetery or crematory Krider's Luth.
Location Westminster, Md.

18 (a) Funeral director David A. Bankard
(b) Address Westminster, E. Main St. Md.

19 (a) SEP 11 1944 (Date rec'd by registrar) (b) Huntington Williams for Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9 1944, at 80 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to Sept. 9 1944, and that I last saw her alive on Sept. 1 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to Arterio sclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Paul Luther M.D.
Address 320 Virginia Ave. Date signed 9/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G20665

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 N. Bond St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 N. Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marion M. Pickard

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife George A. Pickard

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Sept - 14 - 1879

8. AGE: Years 72 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Harford Co. Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER: 12. Name John Presswell

13. Birthplace Harford Co. Md.

MOTHER: 14. Maiden Name Mary Ann Wells

15. Birthplace Harford Co. Md.

16 (a) Informant George A Pickard

(b) Address 24 N. Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 - 11 - 44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Frederick Md

18 (a) Funeral director Wm P Kelly Inc

(b) Address 2435 E Oliver St

19 (a) (Date rec'd by registrar) (b) Registrar

VS SEP 11 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1944, at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to Sept 8 1944, and that I last saw her alive on Sept 8 1944.

Immediate cause of death	Duration
Acute Cardiac Dilatation	Few hrs
Due to	
Due to Myocarditis	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.

Address 753 W Fayette St Date signed Sept 9 1944

(2) G20666

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G20666 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1505 N. Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1505 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Martin

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-8327

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Agnes Martin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11 1877

8. AGE: Years	Months	Days	If less than one day
67	5	-	hr. min.

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business

FATHER
12. Name Wm F. W. Martin
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Emma Lallamy
15. Birthplace Balto. Md.

16 (a) Informant Mary Agnes Martin
(b) Address 1505 N Milton Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Nort Ave.

18 (a) Funeral director John E. Melly Sons
(b) Address 2405 E. Oliver St.

19 (a) SEP 11 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 - 11 - 1944, at 1:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1941, to 9/11 1944, and that I last saw h[illegible] alive on 9/11 1944.

Immediate cause of death — Duration

Carcinomatosis — 16 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Max Baum M. D.

Address 1501 N. Milton Ave Date signed 9/11/44

G20667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20667 / 50

Registered No. G20667

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Months
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 Goodwood Gardens.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Kathrine B. Yates

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife John L. Yates

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1876

8. AGE: Years	Months	Days	If less than one day
67	9m	2	hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name George R. Gross
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Mary Wingerd
15. Birthplace Maryland

16 (a) Informant Dr. John T. Turner Jr
(b) Address Ruxton Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 11/44 (month) (day) (year)
(c) Cemetery or crematory Churchville
Location " Md

18 (a) Funeral director John Oursler Mitchell & Sons
(b) Address 1700 Eutaw Place

19 (a) SEP 11 1944 (Date received by local registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6, 1944 to Sept. 9 1944, and that I last saw her alive on Sept. 9 19 44.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma Pelvis	2 years
Due to Carcinoma of the breast.	2½ years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1941
Major findings of operation: Carcinoma of breast, left.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Neil C. Andrews M. D.
Address Union Memorial Hosp signed 9-9-44

Huntington Williams, MD

G20668

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G20668

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1429 E Lombard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1429 E. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Brothers

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Willis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1881

8. AGE: Years	Months	Days	If less than one day
63	5	22	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joshua Cornish
13. Birthplace N. C.

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Brothers
(b) Address 1429 E Lombard St

17 (a) Burial (b) Date thereof Sept 11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County

18 (a) Funeral director Mrs. Robert A Ellis Dept
(b) Address 1129 N. Carlton St.

19 (a) (b) Huntington Williams, M.D.
(Date received by registrar) SEP. 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1944 to Sept 7 1944 and that I last saw h[illegible] alive on Sept 6 1944.

Immediate cause of death — Duration
Cardio - Renal - Hypertension unknown
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Bernard Hoon M. D.
Address 1207 N Carrollton Ave Date signed 9/7/44

G20669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G20669

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 29 S ABINGTON AVENUE
(c) Hospital or institution: HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 29 S ABINGTON AVENUE
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME CHARLES DORN TAYLOR

3 (b) If veteran, name war: NONE

3 (c) Social Security Account No. 705-07-9260

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: ANNIE B. ZEPP

6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) 7-27-1882

8. AGE: Years 62 | Months 1 | Days 13 | If less than one day: ✓ hr. ✓ min.

9. Birthplace BALTIMORE MARYLAND (Town, county, and state)

10. Usual Occupation MACHINEST

11. Industry or business RAIL ROAD. BRO.

FATHER
12. Name HENRY S. TAYLOR
13. Birthplace BALTIMORE, CITY

MOTHER
14. Maiden Name EUPHEMIA R. MEYERS
15. Birthplace BALTIMORE, CITY

16 (a) Informant MRS. CHAS. TAYLOR
(b) Address 29 S ABINGTON AVENUE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-12-44 (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVENUE

18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1026 REEDS AVENUE.

19 (a) (Date received by registrar) (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1944, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to Sept 9 1944, and that I last saw him alive on Sept 9 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 10 minutes

Due to Arteriosclerotic CVD — 6 months

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Yaffe M.D.
Address 3101 W Baltimore Md. Date signed 9/9/44 M. D.

G20670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1318

G20670

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 N. Stockton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 N. Stockton Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gordon

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years	Months	Days	If less than one day
40			hr. min.

9. Birthplace Frederick - Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Gordon
13. Birthplace Md.

MOTHER
14. Maiden Name Cora
15. Birthplace Md.

16 (a) Informant Mrs. Lucy Mackey
(b) Address 109 N. Stockton St

17 (a) Buried (b) Date thereof 9-11-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans - Md.

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) SEP 11 1944 (b) Washington Williams, M.R.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8- 1944 at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Interstitial Pneumonitis

Due to

Other Conditions Coronary disease, Chronic Nephritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 9-9-44

G20671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20671 Registered No. 1700

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES TURNER

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	S.

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1926

8. AGE: Years	Months	Days	If less than one day
18			hr. min.

9. Birthplace Gamby, Md. (Town, county and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Wesley S. Turner
13. Birthplace Gamby, Md

MOTHER
14. Maiden Name Ida J. Gray
15. Birthplace Gamby, Md

16 (a) Informant Wesley S. Turner
(b) Address Gamby, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/44 (month) (day) (year)
(c) Cemetery or crematory GAMBY Gamby, Md
Location Md

18 (a) Funeral director Geo. H. Kelso
(b) Address 1323 Presstman St

19 (a) SEP 11 1944 Huntington Williams, M.D. (Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1944 at 2 20 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Burns, 2nd & 3rd degree two-thirds of body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-9-44 at a.a. Bet 10 & 11 A.M.
(b) Where did injury occur? Guilford Rd. 5 miles W of Washington Blvd.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Auto car caught fire

Signature H. Z. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 9-10-44

G20672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

Registered No. G20672

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanford Road
(c) Hospital or institution: Sydenham Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2922 Martha Rogers Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert J. Stevens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/29/1936

8. AGE: Years	Months	Days	If less than one day
8	2	11	hr. min.

9. Birthplace New York City, N. Y.
(Town, county, and state)

10. Usual Occupation School Lad

11. Industry or business —

FATHER
12. Name James V. Stevens
13. Birthplace Chicago Ill.

MOTHER
14. Maiden Name Mary Virginia Cranmer
15. Birthplace New York New York

16 (a) Informant Mother
(b) Address 2922 North Rogers Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12-44 (month) (day) (year)
(c) Cemetery or crematory Saint Peters Paul Cemetery
Location Elmira New York

18 (a) Funeral director Ellsworth Comacost
(b) Address 3911 Liberty Heights Ave

SEP 11 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1944, at 10:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944, to Sept 9 1944, and that I last saw him alive on Sept 7 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Bulbar Poliomyelitis	3 Days
Due to	
Other Conditions Pharyngeal Paralysis	

(Include pregnancy within 3 months of death)
Date of operation Sept 9, 1944
Major findings of operation: Tracheotomy
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hospital Date signed 9-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20673

BALTIMORE CITY HEALTH DEPARTMENT

G20673 CERTIFICATE OF DEATH 944a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 712 Winston Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 712 Winston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles G. Schaub.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed~~, or divorced. Married

6 (b) Name of husband or wife Marie Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6 - 1891

8. AGE: Years 53 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George G. Schaub
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Helen Tennis
15. Birthplace Baltimore Md

16 (a) Informant Marie Elizabeth Schaub
(b) Address 712 Winston Ave

17 (a) Burial (b) Date thereof Sept 12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John C. Horgan
(b) Address 3000 E Baltimore

19 SEP 11 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1944 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

20. Signature Knight B. McNally M.D.
Medical Examiner.
Date signed 9/9/44.

G20674

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

Registered No. G20674

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2116 Harford Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2116 Harford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Wm. Sanoles

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-07-7478

4 Sex Male | 5 Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Minnie Bell

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Dec 31 - 1870

8. AGE: Years 73 | Months 8 | Days 10 | If less than one day hr. min.

9. Birthplace Balto. Co.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Club Facility Co

FATHER
12. Name James Sanoles
13. Birthplace Harford Co.

MOTHER
14. Maiden Name Susan Jackson
15. Birthplace Balto. Co.

16 (a) Informant Minnie Bell Sanoles
(b) Address 2116 Harford Ave

17 (a) Burial (b) Date thereof Sept. 13-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director John V. Valentine
(b) Address 2326 Huntington Ave, Md.

19 (a) (Date rec'd by registrar) SEP 11 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1944, at 12 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1928, to Sept. 10 1944, and that I last saw h[illegible] alive on Sept. 10 1944

Immediate cause of death	Duration
Acute Cardiac Dilatation	1 day
Due to Chronic Myocarditis	[illegible]
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John V. Szerbicki M. D.
Address 1802 Eastern Date signed 9-11-44

SZERBICKI

G20675

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 1a

Registered No. G20675

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 511 S.Decker Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 511 S.Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hughes

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Elizabeth Samuels
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.2,1858

8. AGE: Years	Months	Days	If less than one day
85	11	6	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name David Hughes
13. Birthplace Wales

MOTHER
14. Maiden Name not known
15. Birthplace Wales

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 9/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

SEP 11 1944 (Huntington Williams, M.D.
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 1944, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Sept 8 1944, and that I last saw him alive on Sept 7 1944.

Immediate cause of death Chronic myocarditis
cardio-vascular renal dis.
Due to arthritis - rheumatoid -
Due to —
Other Conditions —
chronic passive congestion of liver & kidneys
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration
Aug 15/44 5 yrs.
5 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Louis F. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed

KRUMREIN Sept 9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEARCH RESERVED FOR BINDING

G20676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G20676
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 517 S.Linwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 517 S.Linwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine R.McWilliams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife John McWilliams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3.1882

8. AGE: Years	Months	Days	If less than one day
62	2	5	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Glover
13. Birthplace Baltimore

MOTHER
14. Maiden Name not known
15. Birthplace Baltimore

16 (a) Informant Husband
(b) Address 517 S.Linwood Ave.

17 (a) Burial (b) Date thereof 9/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) SEP 11 19 Washington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1944, at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1944, to Sept 8 1944, and that I last saw her alive on Sept 8 1944.

Immediate cause of death Diabetes Mellitus — Duration 5 yrs

Due to Acute Prostatic Abscess — 5 days

Due to Hemiplegia sl side — 2 yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Geo S Lefevre M. D.
Address 137 S Bolton St Date signed 9/9/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20677

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20677 Registered No. 1242

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1836 N Chester
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1836 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Bodein

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Carrie Bodein
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Mar 21-1867

8. AGE: Years 77 | Months 5 | Days 20 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Ship Gauger Retired
11. Industry or business Standard Oil Co

FATHER
12. Name Charles Bodein
13. Birthplace Balto

MOTHER
14. Maiden Name Dorothea Kenner
15. Birthplace Baltimore

16 (a) Informant Mrs Clarence Rayston
(b) Address 1316 Windermere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location City

18 (a) Funeral director Leo E. Bloemer Funeral Home
(b) Address 2004 E. Baltimore St

19 Huntington Williams, M.D. Huntington Williams, M.D.
(Signature of attending physician)

SEP 11 1944
Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10th 1944 at 7 20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1938 to Sept 3 1944 and that I last saw him alive on Sept 3 1944

Immediate cause of death Acute Dilatation of heart

Due to Arteriosclerosis

Due to Arterio-sclerosis & Hypertension

Other Conditions Cirrhosis, Gall Bladder malignancy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harris G. Ono M. D.
Address 118 Biayuik St Date signed 9/11/44

G20678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20678

AB-89064

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos. 19days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2617 E. Monument St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Maasch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Separated

6 (b) Name of husband or wife Alice ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29-1883

8. AGE: Years	Months	Days	If less than one day
60	8	9	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Maasch
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Yahn
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12/4 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004 E. Oliver St

19 SEP 11 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-8 1944, at 9 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-19 1944, to 9-8 1944, and that I last saw him alive on 9-8 1944.

Immediate cause of death Pulmonary Tuberculosis. Was operated with cavity formation, bilateral

Duration

Due to

Due to

Other Conditions Tuberculous enteritis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. M. Phillips M. D.
Address Balt City Hosp Date signed 9-10-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20679

AB-89473

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

G20679 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2028 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emily Geddes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2-1860

8. AGE: Years	Months	Days	If less than one day
84	4	7	hr. min.

9. Birthplace Baltimore-Md. (Town, county, and state)
10. Usual Occupation Retired School Teacher
11. Industry or business Baltimore City

FATHER
12. Name James Geddes
13. Birthplace ? Md.

MOTHER
14. Maiden Name Sarah Hulse
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) SEP 11 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-9 1944, at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-21- 1944, to 9-9 1944, and that I last saw her alive on 9-9 1944.

Immediate cause of death	Duration
Hypostatic Pneumonia	
Due to Comminuted Inter-trochanteric fract Rt Femur	
Due to	
Other Conditions Senility	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accidental
(b) Date of occurrence 8-10-44 M
(c) Where did injury occur? Home (East Md) (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Fell out of bed

23. Signature H. Leitner M.D.
Address 4940 Eastern Ave Date signed 9-9-44

VS 150

~~TO BE~~ APPROVED BY MEDICAL EXAMINER Howard J. Mueller, M.D.

G20680

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G20680

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Maryland Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. Alexander Apts. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emma V. Boulden

3 (b) If veteran, name war: No
3 (c) Social Security Account No. No

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Charles Newton Boulden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1865

8. AGE: Years 79 | Months 3 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Shew
13. Birthplace Hanover, Pa.

MOTHER
14. Maiden Name Anna V. Vinson
15. Birthplace Balto., Md.

16 (a) Informant W. G. Shew, Sr. (Son)
(b) Address 2407 Harford Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEPT 11 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/1944 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8/1944, to 9/9/1944, and that I last saw her alive on 9/9/1944.

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address [illegible] Date signed 9/9/44

G20681

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 169

Registered No. G20681

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County —
(c) City or town N.Y.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 25 South Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antone Almindo

3 (b) If veteran, name war —

3 (c) Social Security Account No. [illegible]-14-5343

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/1896

8. AGE: Years 48 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Chula, Ba (Town, county, and state)

10. Usual Occupation Piler

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant National Karatuna Union
(b) Address Fleet St. & Broadway - Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly & Talen
(b) Address 403 S. Wolfe Street

SEP 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9- 1944, at 5.15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock, Traumatic

Due to Fractures: mangling & avulsion of Trunk & muscles

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 1945

(a) Date of injury 9-9-44 at 4.15 A M.
(b) Where did injury occur? Ramps. R.R. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Struck by Train.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 9-9-44

V8 151

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20682

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G20682 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1333 S. Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1333 S. Hanover St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Henry J. Tunkoff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary K. Tunkoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16 - 1879

8. AGE: Years	Months	Days	If less than one day
64	10	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Mathew Tunkoff
13. Birthplace Germany

MOTHER
14. Maiden Name Agnes Dietrich
15. Birthplace Germany

16 (a) Informant Mrs. Mary K. Tunkoff
(b) Address 1333 S. Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 12-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway A.G. Cor.

18 (a) Funeral director Elizabeth Clark Fun.
(b) Address 115 E. West St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 11 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1944 at 11:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 6-13- 1944 to 9-9 1944 and that I last saw him alive on 9-9 1944

Immediate cause of death	Duration
Carcinoma	
Due to Cardio-vascular renal disease.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry A. Shields M. D.
Address 1226 Hanover St. Date signed 9-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Ref. G20683

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 N. Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA MATILDA STANLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife George

6 (c) If alive, give age ∞ years

7. Birth date of deceased (mo., day, yr.) April 15, 1869

8. AGE: Years	Months	Days	If less than one day
75	4	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name — Roche
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Clara Virginia Smith
(b) Address 122 N. Milton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Ave

18 (a) Funeral director Earl L. Hess
(b) Address 715 Light St.

19 (a) SEP 11 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10, 1944, at 7:30 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Starvation

Due to Cerebral hemorrhage

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Asst. Medical Examiner.
Date signed 9-10-44

G20684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20684 Registered No. 164a

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 337 Martingale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. L. Ellinghaus

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-3073

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Julia Ellinghaus
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Feb. 2d. 1895

8. AGE: Years	Months	Days	If less than one day
59	6	17	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Asst Foreman
11. Industry or business Bethlehem Steel Co.
FATHER 12. Name Charles C. Ellinghaus Key Highway.
13. Birthplace Balto. Md.
MOTHER 14. Maiden Name Eva Hager
15. Birthplace Maryland
16 (a) Informant Julia C. Ellinghaus
(b) Address 337 Martingale Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md.
18 (a) Funeral director George C. Schwab
(b) Address 801 Frederick Ave.
19 (a) SEP 11 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1944, at 11 50 A M

21. I certify that I took charge of the remains described above, held an Inquest thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒ homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Asphyxiation due to hanging
Due to
Other Conditions Mental dependency
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 10 1944 at 11 A M.
(b) Where did injury occur? 337 Martingale Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Hanged self [redacted]

23. Signature Robert Lee Gutman M.D.
Medical Examiner.
Date signed Sept 11 1944

VS 151

G20685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20685

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S. Bethel.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lizzie Warren

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife. Eddie Warren

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12, 1887

8. AGE: Years 57 | Months 7 | Days 27 | If less than one day hr. min.

9. Birthplace Q A. Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Thomas Parker

13. Birthplace Md

MOTHER 14. Maiden Name Edmonia Pettenar

15. Birthplace Md.

16 (a) Informant Eddie Warren

(b) Address 128 S. Bethel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Elroy D. Wilson

18 (a) Funeral director 1001 Baltimore Ave

(b) Address Funeral Director Philadelphia, Md.

SEP 11 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9 1944, at 4.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Hugh B. McNabb M.D.
Medical Examiner.

Date signed 9/7/44.

G20686 G20686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

√ 47F

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 2141 Penna. Ave St., 13 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME James Chester Stevens — If U. S. Veteran specify WAR

(a) Residence: No. 2141 Penna. Ave St., Ward. (If non-resident give city or town and State)
(Usual place of abode)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	Negro	Married

5a. If married, widowed, or divorced, HUSBAND of (or) WIFE of Anna L. Stevens

6. DATE OF BIRTH (month, day, year) Feb. 2, 1887

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	6	7	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Shoe shiner

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Bootblack Parlor

10. Date deceased last worked at this occupation (month and year) July 1944

11. Total time (years) spent in this occupation 6yrs

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME John L. Stevens

14. BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

MOTHER

15. MAIDEN NAME Helena Bankins

16. BIRTHPLACE (city or town) (State or country) St. Marys Co. Md

17. INFORMANT Annie L. Stevens

(Address) 2141 Penna. Ave

18. BURIAL, CREMATION, OR REMOVAL

Place New Cathedral Date 9/12, 1944

19. UNDERTAKER Charles L. Law

(Address) 802 Madison Ave

20. FILED SEP 11 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept. 9, 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept. 6 1944 to Sept. 9 1944

I last saw him alive on Sept. 8 1944 Death is said to have occurred on the date stated above, at 12:03 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Malignant mediastinal tumor	
Other contributory causes of importance:	

Was an operation performed? Date of

For what disease or injury?

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) C. R. Campbell M. D.

(Address) 718 Dolphin St.

V. S. 3

PERSONS IN CHARGE OF PREMISES WHERE DEATH OCCURS IS REQUIRED BY LAW TO SEE THAT A CERTIFICATE OF DEATH IS FILED WITH THE REGISTRAR OF VITAL STATISTICS, AND TO REPORT THE FACTS OF DEATH TO THE REGISTRAR WITHIN 24 HOURS AFTER DEATH OCCURS. PENALTY FOR NEGLECT OF DUTY IN REPORTING DEATH, OR FOR WILFULLY MAKING FALSE REPORT, IS A FINE OF NOT MORE THAN $100.00. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G20687 G20687

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 N. Charles St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bertha Lee Miller

3 (b) If veteran, name war: ***
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Paul H. Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1869

8. AGE: Years 75 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name J. Stricker Jenkins
13. Birthplace Maryland

MOTHER
14. Maiden Name Clara Vandervoort
15. Birthplace Maryland

16 (a) Informant Mrs. Helen O. Underhill
(b) Address 64 E. 86th. St. New York

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 6/12/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 North Calvert St.

(a) (b)
(Local registrar) Registrar

SEP 11 1944

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1944 at 2:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6/44 19 to 9/10/44 19, and that I last saw h[illegible] alive on 9/9/44 19

Immediate cause of death: Ulcer of Carcinomatous scirrhus of Carcinoma breast. — Duration

Due to:

Due to:

Other Conditions: Arteriosclerotic Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury Jack B. Morgan

23. Signature G. E. Read M.D.
Address Balto, Md. Date signed 9/11/44

G20688 BALTIMORE CITY HEALTH DEPARTMENT G20688
Registered No.

CERTIFICATE OF DEATH 26a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 9/7/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 9/7/44

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1621 T Street, Commodore Apt. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ROSE HARRISON PARROTT

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	-

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 29, 1899 (1889)

8. AGE: Years	Months	Days	If less than one day
55	7	13	hr. min.

9. Birthplace Orange County, Virginia (Town, county, and state)
10. Usual Occupation Technician
11. Industry or business Nat'l. Inst. of Health Bethesda, Md.

FATHER
12. Name John D. Parrott
13. Birthplace Va.

MOTHER
14. Maiden Name Emily E. Farthing
15. Birthplace Va.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial [illegible] (Burial, cremation, or removal) (b) Date thereof Sept 14/44 (month) (day) (year)
(c) Cemetery or crematory
Location Washington D. C.

18 (a) Funeral director Harry M. Armacost
(b) Address 4204 Ridgewood ave

19 (a) 9/12/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Sept. 11, 1944, at 9:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7, 1944, to Sept. 11, 1944 and that I last saw her alive on Sept. 11, 1944.

Immediate cause of death Tularemic pneumonia right lower lobe with septicemia — Duration: Probably several days prior to admission

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address Baltimore, Md. Date signed 9/11/44

VS 150

ECC-55333

G20689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G20689 Registered No. 137 a.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pennsylvania (b) County
(c) City or town Nottingham
(If outside city or town limits, write RURAL and give town)
(d) Street No. R. D. #1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Leasure Markle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: widowed.

6 (b) Name of husband or wife: Sara Freeman Markle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1864

8. AGE: Years 80 | Months 5 4 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER
12. Name David Markle
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sarah Leasure
15. Birthplace Pennsylvania

16 (a) Informant Daughter
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Greensburg Pa
Location Greensburg Pa.

18 (a) Funeral director Calvert P. Rogers
(b) Address 35 N. 4th St Oxford Pa

19 (a) 9/12/44 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1944 at 2:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1944, to Sept. 11 1944, and that I last saw him alive on Sept. 11, 1944.

Immediate cause of death: Cardio circulatory failure — Duration: 3 days m.

Due to

Due to

Other Conditions: Benign prostatic hypertrophy.
(Include pregnancy within 3 months of death)

Date of operation 9-9-44

Major findings of operations: Benign prostatic hypertrophy.

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Neil C. Andrews M. D.

Address Union Memorial Hospital Date signed 9-11-44

G20690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20690 Registered No. 472

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 7/27/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 7/27/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 N. Irvine Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MABEL CLOTILDA PERROTT

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Wid.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	10	hr. min.

9. Birthplace Cloford, England (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business -

FATHER 12. Name Thomas Henry Perrott
FATHER 13. Birthplace Eng.
MOTHER 14. Maiden Name Mary C. Humphries
MOTHER 15. Birthplace Eng.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/11/44 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) 9/12/44 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Sept. 11, 1944, at 11:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 27, 1944, to Sept. 11, 1944, and that I last saw him alive on Sept. 11, 1944.

Immediate cause of death 1. Carcinoma of the right lung with metastases to the mediastinum and hilar lymph nodes; 2. Thrombosis of secondary left pulmonary arteries — Duration 1. 2 mos. 2. Terminal

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/30/44 Pneumonectomy
Major findings of operation: Carcinoma of rt. lung
of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address Baltimore, Md. Date signed 9/11/44

VS 150

Spec.Auth.TC-54474

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

[redacted]G20691 BALTIMORE CITY HEALTH DEPARTMENT [redacted] Reg. No. [redacted]20691

CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 Third Street,
(c) Hospital or institution: (Brooklyn

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1712 W. Durham Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA LONG

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Charles Long
6 (c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): Aug. ? 1873
8. AGE: Years: 71 | Months: / | Days: - | If less than one day: hr. min.
9. Birthplace: Austria (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

MOTHER / FATHER
12. Name: ? Vininger
13. Birthplace: Austria

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Zimmerman
(b) Address: 3811 Third Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-12-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Amatory
Location: Baltimore, Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Avenue & Broadway-

SEP 12 1944 (Date received) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-7-44 19 10.15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/ 1944. to 9/7/ 1944., and that I last saw her alive on 9/7/ 1944.

Immediate cause of death: Cerebral hemorrhage.
Due to:
Due to:
Other Conditions: General and cerrebral arterio sclerosis
(Include pregnancy within 3 months of death)

Duration
7 days
?

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M.D.
Address 1226 Hanover St. Date signed 9/9/44

G20692

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 a

G20692

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Hemlock Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Hemlock Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christina Reichert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Charles T

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1872

8. AGE: Years 72 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry Moog
13. Birthplace ?

MOTHER
14. Maiden Name Magdelene Adelman
15. Birthplace Germany

16 (a) Informant Miss Katherine Reichert
(b) Address 2812 Hemlock Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Pikewood
Location
Funeral director L. J. Ruck
5305 Harford Rd

SEP 12 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1944, at 6 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1944 to 9/8 1944, and that I last saw h alive on Sept 8 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 1 hr.
Due to: Hypertension Cardiovascular — 3 yrs.
Due to: renal disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. J. Ruck
Address 6217 Harford Rd Date signed 9/12/44 M. D.

G20693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 134B

G20693 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3152 Ellerslie ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County --
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3152 Ellerslie ave.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET M. MARTIN

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband of wife John T. Martin
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 23, 1890

8. AGE: Years	Months	Days	If less than one day
54	3	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Morris L. McAuliffe
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret COWAN
15. Birthplace Ireland

16 (a) Informant John T. Martin
(b) Address 3152 Ellerslie avenue

17 (a) Burial (b) Date thereof 9/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral Chas J. Evans. Son Inc
(b) Address 118 N. Mt. Royal Ave

SEP 12 1944 (b) Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 1944 to Sept 10 1944.
and that I last saw her alive on 9/6 1944.

	Duration
Immediate cause of death: Hypostatic Pneumonia	9 days
Due to: General debility	6 mo.
Due to: Vagino vesical fistula	?
Urinary Calculi (bladder)	?
Other Conditions: Resistant bed sore (Spine)	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas M. D.
Address 4600 York Rd Date signed 9/11/44

Huntington Williams, M.D. Registrar

G20694

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20694 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5408 Denmore Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 11 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5408 Denmore Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alverta B. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 15, 1915

8. AGE: Years	Months	Days	If less than one day
28	9	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Alexander Jackson
13. Birthplace West Virginia

MOTHER
14. Maiden Name Rosa Burley
15. Birthplace Md.

16 (a) Informant Mrs Rosa Jackson
(b) Address 5208 Denmore Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)
(c) Cemetery or crematory Arlington Memorial Park
Location Balto. Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 SEP 12 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 11, '44 19 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/44 to 9/11/44, and that I last saw h alive on 9/10/1944.

Immediate cause of death

Due to Pulmonary Tb

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 2134 Druid Hill Ave. Date signed 9/12/44

G20695

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20695 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 N. Duncan Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 N. Duncan Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Steib

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Joseph L. Steib

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 3, 1886

8. AGE: Years 57 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Albert Rust
13. Birthplace Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Husband
(b) Address 901 N. Duncan Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) 9-12-1944 (Date rec'd by Registrar) (b) [illegible] Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 8 1944 at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 7 1944 to Sept 8 1944 and that I last saw h[illegible] alive on Sept 8 1944

Immediate cause of death: Coronary Thrombosis — Duration

Due to: Sclerosis Coronary vessels

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation: Negative

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B J Kelly M.D.

Address 101 N. Linwood Ave Date signed Sept 9/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARC[illegible] RESERVED FOR ENDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20696

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124a

G20696 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Payner
(c) Hospital or institution:
West Balto Gen'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs +
(e) Length of stay in Baltimore (yrs., mos., or days) life ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Poplar Grove
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Aloysius Karwacki

3 (b) If veteran, name war: World War II
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1919

8. AGE: Years 24 | Months 8 | Days 11 | If less than one day: hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation listed as none
11. Industry or business

FATHER
12. Name John Karwacki
13. Birthplace ?

MOTHER
14. Maiden Name Michaelina Dasczuske
15. Birthplace Poland

16 (a) Informant pt's sister
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/44 (month) (day) (year)
(c) Cemetery or crematory Second Hebrew Mem'l
Location Gorsuch Mill Rd.

18 (a) Funeral director Stephen J. Fallon, Inc.
(b) Address 1000 S. Kenwood Ave.

2 Sep 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION 2:30 PM

20. DATE OF DEATH 9-~~10~~ 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1944 to 9-10 1944 and that I last saw h~~im~~ alive on 9-9 1944.

Immediate cause of death Acute necrotizing pancreatitis — Duration 36 hrs

Due to ? acute hepatitis (fatty liver)

Due to alcoholism (chronic)

Other Conditions obesity, myocarditis, acute & chronic pulmonary congestion & edema

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation

of autopsy: as above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank W. Bielemann M. D.
Address West Baltimore General Hosp. Date signed 9-11-44

(OVER)

G20697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

Registered No. G20697

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 9/4/44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 W. Lorraine Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN HERBERT WALSTRUM, JR.

3 (b) If veteran, name war: World War #2
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna B. Anderson
6 (c) If alive, give age 33 years
7. Birth date of deceased (mo., day, yr.) Jan. 5, 1907

8. AGE: Years	Months	Days	If less than one day
37	8	4	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Gov't worker
11. Industry or business -

FATHER
12. Name John H. Walstrum
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary E. Hughes
15. Birthplace Baltimore, Md.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (b) Date thereof Sept 12 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Frederick Rd.
18 (a) Funeral director Main Rt. Supply Co.
(b) Address 7110 Baltimore Rd.
19 (a) Filed by (signature of registrar) (b) Registrar

SEP 12 1944

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Sept. 9, 1944, at 7:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4, 1944, to Sept. 9, 1944, and that I last saw h im alive on Sept. 9, 1944.

Immediate cause of death 1. Perforated Duodenal ulcer- postoperative; 2. Marked pulmonary edema & congestion. — Duration: Unk.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/4/44-Repaired perforated ulcer

Major findings of operation: Perforation of stomach due to ulcer

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify kind of place)
(e) Means of injury

23. Signature J. Calvin M. D.
Address Baltimore, Md. Date signed 9/11/44

Va-14554

G20698

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20698 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3308 Chestnut ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3308 Chestnut ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Shipley.

3 (b) If veteran, name war

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Cora Hare Shipley
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Mar. 5 1880

8. AGE: Years	Months	Days	If less than one day
64	6	6	hr. min.

9. Birthplace Balto. Co. Md (Town, county, and state)
10. Usual Occupation Produce dealer (Retired)
11. Industry or business —

MOTHER / FATHER
12. Name Micajah Shipley
13. Birthplace Md.
14. Maiden Name Margaret Pearce
15. Birthplace Md

16 (a) Informant Mrs Cora H. Shipley.
(b) Address 3308 Chestnut ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Geo. L. Berger Jr
(b) Address 1512 Hollins St.

19 (a) SEP 12 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1944, at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 29 1944, to Sept 10 1944, and that I last saw h/me alive on Sept 10 1944

Immediate cause of death	Duration
Angina Pectoris.	3 hrs.
Due to Cardio-vascular disease.	about 10 yrs
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operations: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cora Shipley
Address 846 W 36th. Date signed 9/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G20699

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3140 CLIFTMONT AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMOROE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3140 CLIFTMONT AVE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT B. McKECHNEY

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 205-03-3168

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of ~~husband~~ or wife BESSIE E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 2, 1881

8. AGE: Years	Months	Days	If less than one day
62	11	10	hr. min.

9. Birthplace SHAMOKIN, PENNA
(Town, county, and state)
10. Usual Occupation SANITATION DEPT.
11. Industry or business GLEN L. MARTIN

FATHER
12. Name WILLIAM McKECHNEY
13. Birthplace PENNA

MOTHER
14. Maiden Name MARGARET SMITH
15. Birthplace PENNA.

16 (a) Informant MRS BESSIE McKECHNEY
(b) Address 3140 CLIFTMONT AVE

17 (a) REMOVAL (b) Date thereof SEPT. 15, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory SHAMOKIN
Location SHAMOKIN, PENNA

18 (a) Funeral director WILLIAM COOK, INC.
(b) Address 1217 ST. PAUL ST.

1944 SEP 16 AM
(Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 13 1944 at 4 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23, 1943 to Sept 11, 1944 and that I last saw him alive on Sept. 11, 1944.

Immediate cause of death	Duration
Carcinoma of Lung	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Weinz M.D.
Address 927 E North Ave Date signed 9/12/44

G20700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20700 Registered No. 186a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address PARK HEIGHTS AVE
(c) Hospital or institution: MT. SINAI HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 WESTWOOD AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA SHAPIRO

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: SOLOMON
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1869
8. AGE: Years 75 | Months | Days | If less than one day hr. min.
9. Birthplace: RUSSIA (Town, county, and state)
10. Usual Occupation: NONE
11. Industry or business

FATHER
12. Name: DAVID
13. Birthplace: RUSSIA

MOTHER
14. Maiden Name: EVA
15. Birthplace: RUSSIA

16 (a) Informant: HARRY SHAPIRO
(b) Address 2012 BUXTON AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHILA PO & HAMILTON AVE

18 (a) Funeral director: Jack Levin Inc
(b) Address 1439 E Balto St

19 (a) SEP 12 1944 (Date received by Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12-44 19 at 12 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to 9/11 1944 and that I last saw h[illegible] alive on 9/11 1944

Immediate cause of death: Cardio-Renal Vascular Disease — Duration 1 yr
Due to —
Due to —
Other Conditions: Fracture of head of left femur — 8 weeks
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence July 20 1944 at 7 AM
(c) Where did injury occur? 2020 Westwood Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work? no
(e) Means of injury: Slipped and fell to floor

23. Signature: Wm. Sarahan M.D.
Address 3128 W North Ave Date signed 9/4/44

Approved: Robert Lee Graham M.D. Sept. 4 1944

G20701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20701 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Gene Sts.
(c) Hospital or institution: Union Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Chilham Rd (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country —

3 (a) FULL NAME ELSIE HAYDEN (Elsa Graffin Hayden)

3 (b) If veteran, name war: 720
3 (c) Social Security Account No.:
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Eugene W. Hayden
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Jan 13 1880
8. AGE: Years 64 | Months 7 | Days 29 | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, or state)
10. Usual Occupation Managerial Position nurs
11. Industry or business Goucher College
FATHER 12. Name John H. Graffin Jr.
13. Birthplace Baltimore Md
MOTHER 14. Maiden Name Nellie Hayden
15. Birthplace Baltimore Md
16 (a) Informant Mr. Don H. Hayden (Son)
(b) Address 6014 Smith Ave City
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville
18 (a) Funeral director Sherwood & Nonnemacher
(b) Address 108 W Mt Royal Ave
Sept 12 1944 (Date rec'd by registrar) (Signature) Hampton Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1944 at 10:25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1944 to 9/11 1944 and that I last saw her alive on 9/11 1944.

Immediate cause of death: Coronary Thrombosis — Duration: 1 day.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. Robert Marker M. D.
Address Union Hospital Date signed 9/11/44
Baltimore Md

G20702

BALTIMORE CITY HEALTH DEPARTMENT X G20702

CERTIFICATE OF DEATH ✓ 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2-20
(e) Length of stay in Baltimore (yrs., mos., or days) 1-2-20

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York (If outside city or town limits, write RURAL and give town)
(d) Street No. 477 Madison Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. William J. Connolly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 1880

8. AGE: Years	Months	Days	If less than one day
63	8	20	hr. min.

9. Birthplace New York, New York (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name Thomas Connolly
13. Birthplace Ireland

MOTHER
14. Maiden Name Katherine Kiernan
15. Birthplace Ireland

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. City - Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 103 W. NORTH AVENUE

19 (a) 9-12-1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1944, at 8:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1943, to Sept 10 1944, and that I last saw him alive on Sept 10, 1944

Immediate cause of death: Cerebral hemorrhage — Duration: 3 Days

Due to:

Due to:

Other Conditions: Arteriosclerosis — 1 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harvey D. Gaul M. D.
Address 33 W. Lexington St. Balto. Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

G20703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 B

G20703
Reg. District No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3707 Fernhill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3707 Fernhill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES SAMUEL STIRLING

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen Atwill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1870

8. AGE: Years	Months	Days	If less than one day
74	7	27	hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)
10. Usual Occupation Engineer - retired
11. Industry or business Pittsburgh Plate Glass

FATHER
12. Name James Stirling
13. Birthplace Annapolis, Md.

MOTHER
14. Maiden Name Mary Frazier
15. Birthplace Annapolis, Md.

16 (a) Informant Mrs. Helen Atwill
(b) Address 3707 Fernhill Ave.

17 (a) Burial (b) Date thereof 9/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.
18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.
SEP 12 1944
19 (a) Huntington Williams, Jr.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 10, 1944, at 1:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1944 to 9-10-1944 and that I last saw him alive on 9/9 1944.

Immediate cause of death: Angina Pectoris

Due to:

Due to: Bronchial Pneumonia

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy:

Duration
5 days
7 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work?
(Specify type of place)
(e) Means of injury X
23. Signature A. G. Hedrick M.D.
Address 3901 Harwood Pl. Date signed 9/11/1944

G20704 G20704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (93)

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2105 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mr. William Beck

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mrs. Emma Beck
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 15, 1872

8. AGE: Years 72 | Months 1 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Barber (retired)
11. Industry or business

FATHER
12. Name Anton Beck
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wolfe
15. Birthplace Germany

16 (a) Informant Mr. W. A. Beck
(b) Address 2105 Cliftwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/12/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem. Pk. Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

9 12 1944 (Date filed by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10 1944 at 7 25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1944 to 9-10 1944, and that I last saw him alive on 9-10 1944

Immediate cause of death	Duration
Cardio-Resp failure	
Due to Arteriosclerotic Heart disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Glenn P. Grove
Address Union Memorial Hosp. Date signed 9/12/44

G20705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1318

G20705 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 John St.
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 John St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JENNIE DONNELLY

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9, 1883

8. AGE: Years	Months	Days	If less than one day
61	1	1	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Donnelly
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Jennie Geddes
15. Birthplace Balto., Md.

16 (a) Informant Mr. H. Gordon Donnelly
(b) Address 915 North Hill Rd.

17 (a) Burial (b) Date thereof 9/12/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto. Md.

Sept 12 1944 [illegible]
(Filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10, 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1-44 to Sept 10/44, 19; and that I last saw her alive on Sept 10/1944.

The cause of death
Chronic Myocarditis
Acute Edema Lungs
Uremia
Chronic Nephritis

Duration
2 yrs
2 days
2 wks.

Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry C Hewitt M.D.
Address 1924 W Mount St Date signed Sept 12 1944

G20706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83B

Registered No. G20706

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 419 [redacted] Ave (If rural give location)
(e) Citizen of foreign country? Latvia (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS, Harry DORRETT

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-63-3466

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Clarabelle Thomas
6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Mar 13, 1917

8. AGE: Years	Months	Days	If less than one day
27	5	27	..... hr. ..... min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation trouble Shooter
11. Industry or business Bendix Corp.

FATHER
12. Name T. Luther Thomas
13. Birthplace N.C.

MOTHER
14. Maiden Name Catharine Riley
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.
12 (a) [illegible] director [illegible] Funeral Home
(b) Address [illegible]
SEP 12 1944 (b) [illegible] Registrar

VS 180 (Duplicate copy)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1944 at 11:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1944 to 9-10 1944 and that I last saw h[illegible] alive on 9-10 1944.

Immediate cause of death: Infarct of the brain — Duration: 3 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed

G20707 Md/Gonski [redacted] G20707

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1576

[redacted]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Caroline St
(c) Hospital or institution: St. Joseph. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Portugal St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Marian J. Wadkowski

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 21-1944

8. AGE: Years	Months	Days	If less than one day
		22	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business " "

FATHER
12. Name Alexander Wadkowski
13. Birthplace Penn

MOTHER
14. Maiden Name Aniela Rybicki
15. Birthplace " Baltimore "

16 (a) Informant Alex Wadkowski
(b) Address 1605 Portugal St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Back Rd

18 (a) Funeral director William Fogerty
(b) Address 161 Eastern Ave

19 (a) (b) Registrar

SEP 12 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1944 1940 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1944 to 9/11 1944 and that I last saw her alive on 9/11 1944

Immediate cause of death: Congenital Heart Disease

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles J. Iannucci M.D.

Address St Joseph Date signed 9/11/44

G20708

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20708

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~57~~ 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard Co.
(c) City or town Elkridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. Montgomery Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Helen Gertrude Soper Harman.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife George Philip Harman

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1877

8. AGE: Years	Months	Days	If less than one day
67	7	0	hr. min.

9. Birthplace Elkridge, Maryland
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER 12. Name Mr. Charles Soper

13. Birthplace Elkridge

MOTHER 14. Maiden Name Alberta Jeffers

15. Birthplace

16 (a) Informant Edna N. Harman

(b) Address Elkridge, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13, 1944 (month) (day) (year)

(c) Cemetery or crematory Meadowridge

Location Dorsey, Md.

18 (a) Funeral director Leslie Carey

(b) Address Elkridge, Md.

SEP 12 1944

19 (a) (b) Huntington Williams, M.D.

SEP 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1944 at 1.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/31 1944 to 9/10 1944, and that I last saw h[er] alive on 9/10 1944

Immediate cause of death Septicemia — Duration 2 wks

Due to Osteomyelitis

Due to Fracture Rt femur

Other Conditions Hypertension, Cardiovascular disease
(Include pregnancy within 3 months of death)

Date of operation 9-2-44

Major findings of operation: Rt hip: fracture

of autopsy: not done.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Fell & broke hip
(b) Date of occurrence 8/28 at M
(c) Where did injury occur? Elkridge Howard Md
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home While at work? No
(Specify type of place)
(e) Means of injury Tripped on under path

23. Signature Le Roy W. Tilt M. D.

Address University Hospital Date signed 9/10/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR ENDING

G20709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G20709

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1717 Jackson St.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1717 Jackson St.,
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Pancratius Leo Frommknecht

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-09-5794

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Emma E. Frommknecht
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1874

8. AGE: Years	Months	Days	If less than one day
69	10	2	hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation
11. Industry or business American Sugar Refining Co.

FATHER
12. Name John Frommknecht
13. Birthplace Germany

MOTHER
14. Maiden Name Apolonia Schumanski
15. Birthplace Germany

16 (a) Informant Mrs. Emma E. Frommknecht
(b) Address 1717 Jackson St.,

17 (a) Burial (b) Date thereof Sept. 13-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Park
Location Elkridge, Md.

18 (a) Funeral director H. Howard Strong
(b) Address 3207 W. North Ave.,

19 SEP 13 1944 (Signature) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1944, at 9:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1942, to 9-9-1944, and that I last saw him alive on 9-8 1944.

Immediate cause of death	Duration
Carcinoma of Sigmoid Colon	2 yr.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. A. Collod, M. D.
Address 707 E. Fort Ave, Date signed 9-11-44

G20710

BALTIMORE CITY HEALTH DEPARTMENT X ✓ 939

CERTIFICATE OF DEATH

Registered No. G20710

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Balt. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Dayton (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

✓

3 (a) FULL NAME William HAWES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884-4-2

8. AGE: Years 60 | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name Daniel Hawes
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Elliott
15. Birthplace Va.

16 (a) Informant Mrs Elsie Hawes
(b) Address Daniels md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18 (a) Funeral director J. C. Higinbotham
(b) Address Ellicott City Md

19 SEP 13 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10 1944, at 3 35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1944, to 9-10 1944, and that I last saw him alive on 9-10-1944.

Immediate cause of death	Duration
Bronchopneumonia,	
Due to Carotide decompensation	
Due to arteriosclerotic heart disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Huntington Williams M. D.
Address 2339 Eutaw Place Date signed 9-13-1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20711
459061

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c ✓

Registered No. G20711

MARYLAND RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1414 Inc E Eldermy Pk (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Daisy Dean

3 (b) If veteran, name war (c) Social Security Account No.

4 Sex: Female | 5 Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Raymond

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-29-00

8. AGE: Years 43 | Months 11 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Harry Keene

13. Birthplace Md.

MOTHER 14. Maiden Name Orpilla Banks

15. Birthplace Md.

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9/14/1944 (burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cemetery

Location Liberty Road Md

18 (a) Funeral director Sewell & Bayne

(b) Address Cambridge Md

19 SEP 13, 1944 (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 11 1944 at 3:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12 1944 to Sept. 11 1944 and that I last saw her alive on Sept 11 1944 -

Immediate cause of death Pulmonary Edema Failure

Due to Hypertensive Heart Disease Syp.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Benecin M.D.

Address J Hopkins Hospital Date signed 9-11-44

G20712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G20712

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 336 S. Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 336 S. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Ratcliffe

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-8235

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Nellie Tucker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3, 1888

8. AGE: Years	Months	Days	If less than one day
56	1	8	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Crown Cork & Seal Co.

FATHER
12. Name Cephas Ratcliffe
13. Birthplace Virginia

MOTHER
14. Maiden Name Henrietta Hughes
15. Birthplace Virginia

16 (a) Informant Mrs. Nellie Ratcliffe
(b) Address 336 S. Bruce St

17 (a) Burial (b) Date thereof 9.13.44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oakwood Cem.
Location Richmond, Virginia

18 (a) Funeral director Harry H. Wiltshe
(b) Address 4101 Edmondson Ave.

19 SEP 13 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1944 at 9:40 P.M.

21. I certify that I attended the deceased from 1944 to Sept 11th 1944 and that I last saw him alive on Sept 11th 1944

Immediate cause of death	Duration
Acute dilation of heart	2 hours
Due to Cerebral Hemorrhage	2 Weeks
Due to arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. J. Faulkner M. D.
Address 100 N. Smallwood Date signed 9/12/44

VS 150

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20713

459090

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

56D

Registered No. G20713

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County.....
(c) City or town Brockway
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Dale Irvin Miller

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 9 1920

8. AGE: Years	Months	Days	If less than one day
24	6	3	.....hr. .....min.

9. Birthplace Penna -
(Town, county, and state)

10. Usual Occupation — Farmer

11. Industry or business

FATHER 12. Name Irvin Miller

13. Birthplace Penn

MOTHER 14. Maiden Name Winifred Atwell

15. Birthplace Penn -

16 (a) Informant Record -

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/44 (month) (day) (year)

(c) Cemetery or crematory Brockway

Location

18 (a) Funeral director Wm Cook Jr

(b) Address 1217 St Paul St

19 SEP 13 1944 (Date rec'd by registrar) (b) Huntington Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1944 at 4 P. M 38

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 13th 1944 to Sept 12 1944 and that I last saw h[illegible] alive on Sept 12 1944

Immediate cause of death Brain Tumor — Duration 3 years

Due to.....

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

Date of operation Sept 2, 1944

Major findings of operation: Brain Tumor, Benign

of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Hugo V. Ruggli M. D.

Address Johns Hopkins Hosp Date signed 9-12-44

G20714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G20714

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.A.
(b) Street address 4302 Groveland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4302 Groveland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma J. Kirkwood

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widow

6 (b) Name of husband or wife Samuel W. Kirkwood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1857

8. AGE: Years	Months	Days	If less than one day
86	8	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Craig
13. Birthplace unknown

MOTHER
14. Maiden Name Emiline Marshall
15. Birthplace unknown Liver.

16 (a) Informant Mr. Wm. H. ~~Zeiman~~, Exec.
(b) Address 3115 Clifton Ave.

17 (a) Burial (b) Date thereof 9/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(Address) Balto., Md.

SEP 13 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1944, at 8:00 AM

21. I certify that I took charge of the remains described above, held an Inquiry - Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic C.V disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dexter W. Sulinski M.D.
Medical Examiner.
Date signed 9/12/44

G20715 G20715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1918 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1918 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cordelia Ellis Powell
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Robert S. Powell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1865

8. AGE: Years 79 | Months — | Days 29 | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business

FATHER
12. Name John Henry Ellis
13. Birthplace Westminster Md

MOTHER
14. Maiden Name Amelia Ann Richardson
15. Birthplace Powellsville Md

16 (a) Informant Mary Powell Northam
(b) Address 1918 Linden Ave

17 (a) Burial (b) Date thereof Sept. 14 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel Meth. Cemetery
Location Snow Hill, Md

18 (a) Funeral director Wm. T. Tickner & Sons
(b) Address North & Payson

SEP 13 1944 (Date rec'd by registrar) (b) Huntingtown Md Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11th 1944, at 10:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1944 to Sept 11th 1944, and that I last saw her alive on Sept 11th 1944

Immediate cause of death Cardiac Asthenia — Duration 5 days

Due to Arteriosclerosis — Duration 2 to 3 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert E. Zapp M. D.
Address 3048 W. North Ave Date signed 9/11/44

G20716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20716 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 7
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Brighton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Joseph Duerr (or Daurr)

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Nancy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1872

8. AGE: Years	Months	Days	If less than one day
72	4	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Machinist Retired
11. Industry or business B. & O. R. R.

FATHER
12. Name Frank Duerr
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara
15. Birthplace Germany

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 9/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Greenspring, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 13 1944 (b) Huntington Williams M.D.
(Date Rec'd by Local Reg.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 9, 1944 at 9:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1944 to Sept. 9 1944 and that I last saw h. ing alive on Sept. 5 1944.

Immediate cause of death Myocardial insufficiency —

Due to Arteriosclerotic type of heart disease with hypertension and congestive failure

Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
Years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Michael M. D.
Address 2901 Edmund Date signed 9/11/44

G20717

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G20717

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 Sterrett St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 Sterrett St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHLOE EMMA WEBB

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1873

8. AGE: Years	Months	Days	If less than one day
70	9	23	hr. min.

9. Birthplace Lancaster Co., Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Unknown Pittman
13. Birthplace Unknown

MOTHER
14. Maiden Name Alice Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Helen Leonard
(b) Address 1108 Sterrett St.

17 (a) Burial (b) Date thereof 9/14/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn Maryland

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 13 1944 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1944, at 10:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-8 1935, to 9-11 1944 and that I last saw h alive on 9/11 1944.

Immediate cause of death Acute Cardiac Failure — Duration Ida

Due to Chronic Myocarditis

Due to Coronary Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph G Lankadis
629 Washington Blvd Date signed 9/12/44 M.D.

G20718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G20718

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 735 N. Fairmount Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-03-2311

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Elizabeth Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 1899

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Balto.
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business

FATHER
12. Name Joseph Taylor
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary F.
15. Birthplace Va

16 (a) Informant Edith Maloney
(b) Address 773 Vine Street

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept. 13 44
(month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Balto.

18 (a) Funeral director Walter B. Griggs
(b) Address 139 W. Hamburg Street

19 (a) SEP 13 1944 (b) [illegible] Williams M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 7 19 44, at 8:40 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Gastric Ulcer.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Jos L. Wollenmuller M.D.
Medical Examiner.
Date signed Sept. 13 1944.

G20719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D

G20719 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1110 RIDGELY ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1110 RIDGELY ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM H. COOK.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex MALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced MARRIED

6 (b) Name of husband or wife MARY M. COOK

6 (c) If alive, give age 90 years

7. Birth date of deceased (mo., day, yr.) MAY 30-1861

8. AGE: Years 83 | Months 3 | Days 12 | If less than one day ___ hr. ___ min.

9. Birthplace BALTIMORE MD (Town, county, and state)

10. Usual Occupation RETIRED

11. Industry or business

FATHER 12. Name CHARLES H. COOK

13. Birthplace MD.

MOTHER 14. Maiden Name JULIA A. HISSEY

15. Birthplace MD

16 (a) Informant MARY. M. COOK.

(b) Address 1110 RIDGELY. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-15-44 (month) (day) (year)

(c) Cemetery or crematory MT. OLIVET

Location BALTO MD

18 (a) Funeral director Bernard C Hawkins

(b) Address 121 E West St

19 SEP 13 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Address 2708 Hallins Ferry Rd Date signed 9/13/44

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 11 1944 at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 to Sept 11 1944, and that I last saw him alive on Sept 10 1944.

Immediate cause of death Pulmonary Hemorrhage — Duration few minutes.

Due to Arterio Sclerosis

Due to Coronary Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature H W Williams M. D.

G20720

282905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 B

Registered No. G20720

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3416 Auchentoroly Terra
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Louvenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-9-83

8. AGE: Years	Months	Days	If less than one day
61	3	2	hr. min.

9. Birthplace La. (Town, county, and state)

10. Usual Occupation Moving Picture

11. Industry or business Salesman

FATHER 12. Name Louis Louvenberg

13. Birthplace La

MOTHER 14. Maiden Name Rosa Marx

15. Birthplace La

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel

Location O'Donnel St

18 (a) Funeral director Earl Lewis Inc

(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

SEP 13 194

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11-1944 at 1:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3-1944 to 9-11-1944 and that I last saw him alive on 9-11-1944

Immediate cause of death Carcinoma of the bladder with generalized Carcinomatosis

Due to

Due to

Other Conditions Syphilis

(Include pregnancy within 3 months of death)

Date of operation Feb. 1943

Major findings of operation: Benign Prostatic Hypertrophy. Ca of Bladder

of autopsy: None

Duration	
18 months	
+	
Years	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr. M. D.

Address Johns Hopkins Hospital Date signed 9/12

G20721

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20721

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G20721

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Ft
(c) Hospital or institution: Jewish Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 Parkwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie Katz

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4 Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or Business

FATHER: 12. Name Joseph Russey
13. Birthplace Russia

MOTHER: 14. Maiden Name Anna
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-47 (month) (day) (year)
(c) Cemetery or crematory Herzog Cem
Location Park Rd & Rogers Ave

18 (a) Funeral director Jos. Lamm Son
(b) Address 1439 E. Baltimore St

19. (a) Date received (Date registrar received certificate) SEP 13 1944 (b) Registrar Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1947, at 7:59 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-5 1947, to 9-12 1947, and that I last saw h alive on 9-12 1947

Immediate cause of death Cardiac failure

Due to Auricular fibrillation

Due to Arteriosclerotic cardiovascular disease

Other Conditions Fracture of unknown origin

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Meiselas M. D.
Address Date signed 9-12-47

Edward E. Meiselas

G20722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G20722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1119 Division St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Division St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norma D. Vincent

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Arthur Vincent
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-10-1891

8. AGE: Years 53 | Months | Days 2 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Dietitian

11. Industry or business

FATHER 12. Name George Garino
13. Birthplace Va

MOTHER 14. Maiden Name Mary ? ?
15. Birthplace

16 (a) Informant Sara Means
(b) Address 1119 Division

17 (a) Burial (b) Date thereof 9-15-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Williams A Jackson
(b) Address 916 Penna ave

19 (a) (b) Huntington Williams, Md

SEP 13 1944

FD 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1944 at 10 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1944 to 9-12 1944 and that I last saw h alive on 9-11 1944

Immediate cause of death	Duration
Hypertension	
Due to Cardiovascular Disease	2 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Atwell Jones M. D.
Address 5-5-4 Dolphin St Date signed 9-13-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20723

130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 876 Walbert Ave
(c) Hospital or institution Doctors Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 Annabelle Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gable.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male.

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/17/44

8. AGE: Years | Months | Days 25 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden Name Evelyn Gable

15. Birthplace Balto Md.

16 (a) Informant Evelyn Gable.

(b) Address 610 Annabelle Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 11 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 13 1944 (b) Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11-1944, at 6.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-17-1944, to Sept 11 1944 and that I last saw h alive on 19

Immediate cause of death Acute Nephritis — Duration 25 days

Due to Chronic Nephritis

Due to Pneumonia of mother

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 8/17/44

Major findings of operation: Caesarean

of autopsy: on mother

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis J. Sloan M.D.

Address 876 Walbert Ave Date signed 9/11/44

F 2144

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G20724 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4020 Sixth St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 1/4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 25 Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 4020 6th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ira Albert Doughty

3 (b) If veteran, name war | 3 (c) Social Security Account No. 215-10-9707

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband~~ or wife: Mary Doughty

6 (c) If ~~wife~~ give age years

7. Birth date of deceased (mo., day, yr.) Nov 29 1878

8. AGE: Years 65 | Months 9 | Days 14 | If less than one day: hr. 13 min.

9. Birthplace Washington N.C. (town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business Hochschild Kohn Co

FATHER
12. Name Mr Betsy Doughty
13. Birthplace Washington N.C

MOTHER
14. Maiden Name Mary Arthur
15. Birthplace Balto - Md

16 (a) Informant Mrs Doughty
(b) Address 4020 Sixth St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15 44 (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery Co.
Location Baltimore Co.

18 (a) Funeral director Miller & Lehnen
(b) Address 3914 E. Hanover St.

19 (a) [illegible] Huntington Williams M.D. Registrar

SEP 13 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 19 44 at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 10 19 44 to Sept 10 19 44 and that I last saw him alive on Sept 10 19 44

	Duration
Immediate cause of death: Ventricular fibrillation of the heart	3 days
Due to: degeneration of heart muscles	
Due to: adhesive pericarditis	
Other Conditions: epithelioma of the nose	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jane Neubauer M. D.
Address 914 Patapsco Ave Date signed Sept 14 44

Jane Neubauer

G20725

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20725 Registered No. 1352

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 31 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1013 Whatcoat St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Levi Griffin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife: Lola
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1912

8. AGE: Years 31 | Months 10 | Days -0- | If less than one day hr. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual Occupation: Bottle Inspector
11. Industry or business: Silver Club Factory

FATHER
12. Name: John Griffin
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden Name: Mary Campbell
15. Birthplace: Virginia

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14-1944 (month) (day) (year)
(c) Cemetery or crematory: Mt. Auburn
Location: West Port

18 (a) Funeral director: J. Brooks.
(b) Address: 1437 N. Carey St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar
SEP 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1944, at 10:05 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28, 1944 to Sept. 11, 1944 and that I last saw him alive on Sept. 11 1944.

Immediate cause of death	Duration
Chronic Pulmonary Tuberculosis	2
Due to:	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Shea Hall M.D.
Address: Balt City Hosp Date signed 9/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20726
City

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH 97

G20726

Reg. Dist. No. 36

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 5313 Edmondson Ave
How long in hospital or institution? 6 mos. 12 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3806 Parkside Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Fannie May Roberts

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William Lewis
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) Feb 6 1880

8. AGE: Years	Months	Days	If less than one day
64	6	13	____ hrs. ____ min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation At Home
11. Industry or business
FATHER 12. Name James Kirby
13. Birthplace Baltimore Md
MOTHER 14. Maiden name Eleanor Udin
15. Birthplace Baltimore Md
16. Interment Mt Vernon R. Roberts
Address 3806 Parkside Drive
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 24. 44 (month) (day) (year)
Cemetery or crematory Parkwood
Location Parkville, Balto Co Md.
18. Funeral Director L. J. Reck
Address 5305 Harford Rd
19. 8/21 19 44 (Date rec'd by registrar) [illegible] County Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 19 44 at 6P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1 19 44 to Aug 19 19 44
and that I last saw h[illegible] alive on Aug 19 19 44
Immediate cause of death Cerebral Apoplexy
Due to Sclerosis

DURATION
1 yr

Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Catonsville Md Date signed 8/21

G20727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 737

Registered No. G20727

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 33 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Faison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/28/44

8. AGE: Years | Months: 4 | Days: 19 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Cleveland Faison
13. Birthplace NC

MOTHER
14. Maiden Name Emma Bruce
15. Birthplace NC

16 (a) Informant Emma Faison
(b) Address 1211 Jefferson St

17 (a) Burial (b) Date thereof 9-13-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary Cem
Location A. R. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E Preston St

SEP 13 1944 (Date rec'd by registrar) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 10 1944, to Sept 12 1944, and that I last saw h[illegible] alive on Sept 12 1944.

Immediate cause of death: Sickle Cell Anemia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9/13/44

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20728 Borchert

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No. G20728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2109 Wilhelm St
(c) Hospital or institution: 205
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2109 Wilhelm St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Otto Borchert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Late Anna Dittmar
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 12, 1863

8. AGE: Years	Months	Days	If less than one day
81	7	28	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER 12. Name — Borchert
FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name —
MOTHER 15. Birthplace Germany

16 (a) Informant William Zimmt
(b) Address 237 S. Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Wittke
(b) Address 4101 Edmondson Ave

19 SEP 13 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 10 1944, at 11.40 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 26 1944 to Sept 9 1944, and that I last saw him alive on Sept 9 1944.

Immediate cause of death	Duration
Carcinoma of Prostate	4
Due to	
Due to	
Other Conditions Arteriosclerosis Cardio Vascular Disease (Include pregnancy within 3 months of death)	?

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Earle R. Ortney M. D.
Address 3 N. W. Lombard St Date signed 9/11/44

G20729 T.G.P--89704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20729 Registered No. 1136

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 North Carey Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Matthew Brown

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Separated

6 (b) Name of husband or wife Mamie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1895

8. AGE: Years	Months	Days	If less than one day
49	?	?	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept 13 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Baltimore Md
18 (a) Funeral director Adolphus Hall
(b) Address 1847 Druid Hill Ave
19 SEP 13 1944 (Date rec'd by registrar) Hamilton Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11 1944 at 5:55P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/8 1944 to 9/11 1944; and that I last saw h— alive on 9/11 1944.

Immediate cause of death	Duration
Pulmonary Hemorrhage	Minutes
Due to Chronic Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Shea Holle
Address Balt City Hosp Date signed 9/12/44 M. D.

G20730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V46 B2

Registered No. G20730

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hos
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 637 N. Calhoun (If rural give location)
(e) Citizen of foreign country? (Yes or No) Y
If yes, name country

3 (a) FULL NAME Roberta Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-99

8. AGE: Years 45 Months 2 Days 24 If less than one day hr. min.

9. Birthplace Rutland Mass (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Robert Jones
13. Birthplace Md

MOTHER
14. Maiden Name Laura Gordon
15. Birthplace Md

16 (a) Informant Laura Jones
(b) Address 637 N. Calhoun

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)
(c) Cemetery or crematory Zaidaemille Church
Location Q & Lo Md

18 (a) Funeral director Sam'l R. Chase Hon
(b) Address 638 N. Gilmor St.

19 (a) Date received (Registrar) SEP 13 1944 (b) Hamilton Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/10 1944 at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/1 19 44 to 9/10 19 44, and that I last saw h alive on 9/9 1944

	Duration
Immediate cause of death Cyanosis of Stomach	2 hrs
Due to Luminal Narcosis previous 2 days	
Due to Post operative shock	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/5

Major findings of operation Excision

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Keelan M. D.
Address 600 N. Broadway Date signed 9/11/44

G20731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 140 S. Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA LEMEL

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Leite Samuel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Isaac Zimmerman
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Jake Zimmerman
(b) Address 128 N. Eutaw St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 13 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Rest
Location Bowleys Lane

18 (a) Funeral director Sol Levinson & Bro
(b) Address 1124-26 W North ave

SEP 13 1944 (Date rec'd by registrar) Huntington Williams M.D.

V8 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes mellitus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. J. Wollenweber M.D.
Medical Examiner.

Date signed 8-17-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20732 / 51D

Registered No. G20732

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2903 Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 79 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~3911 Liberty Heights Ave~~ 2903 Arlington Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William S. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 3 - 1865

8. AGE: Years	Months	Days	If less than one day
79	8	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Brush Manufacturer

11. Industry or business

FATHER
12. Name Sinclair S. Carroll
13. Birthplace Harford Co. Md.

MOTHER
14. Maiden Name Emma White
15. Birthplace Maryland

16 (a) Informant James B. Magroggan
(b) Address 2720 Overland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director Ellsworth Company
(b) Address 3911 Liberty Heights Ave

19 (a) (Signature of local registrar) Registrar

SEP 13 1944

VS 150

Huntington-Williams, 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11, 1944 at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 30 1944 to Sept. 10 1944, and that I last saw him alive on Sept. 10 1944.

Immediate cause of death: Acute myocarditis — Duration: 2 wks

Due to: Uremia Urinary retention

Due to:

Other Conditions: Carcinoma of Penis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. V. Harbold M.D.

Address 4706 Harford Road Date signed 9/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20733 — G20233

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2713 Northern Pkway (If rural give location)
(e) Citizen of foreign country? Greece (Yes or No) If yes, name country

3 (a) FULL NAME George Pappas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	[redacted]

6 (b) Name of husband or wife Virginia, 27 — 6 (c) If widow, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1900

8. AGE: Years	Months	Days	If less than one day
44	2	25	hr. min.

9. Birthplace Turkey - (town, county, and state)
10. Usual Occupation Proprietor
11. Industry or business Lunch Room

FATHER
12. Name Thomas Pappas.
13. Birthplace Turkey

MOTHER
14. Maiden Name Angela —
15. Birthplace Turkey

16 (a) Informant Mrs Virginia Pappas
(b) Address 2713 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/13/44 (month) (day) (year)
(c) Cemetery or crematory Woodland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) (b)

SEP 13 1944
Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9.10.44 19 , at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8.29.44 19 , to 9.10.44 19 , and that I last saw h alive on 8.29.44 19

Immediate cause of death Cardiovascular collapse — Duration

Due to Carcinoma of bladder

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L.T. Gallagher M. D.
Address Md General Hosp Date signed 9/11/44

L.T. Gallagher

G20734

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

G20734

CERTIFICATE OF DEATH 95B

Reg. Dist. No. .....

1. PLACE OF DEATH:
County. 6725 Boston Ave.
City or town. Balto Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County .....
City or town. Balto
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6725 Boston Ave
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Georg Knapp

3.(b) Social Security Number 213-07-8741

4. Male	5. White	6.(a) Married

6.(b) Name of husband or wife. Anna Knapp
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 21 1891

8. AGE: 53. Years | Months 5 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)
10. Usual occupation Steel Worker
11. Industry or business Steel Mills

FATHER
12. Name Mark Knopp
13. Birthplace Germany

MOTHER
14. Maiden name Christine Jan
15. Birthplace Germany

16. Informant Anna Knapp
Address 6725 Boston Ave

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9 15 44 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Beltsville Md
18. Funeral director James Brundage
Address 1407 Eastern Ave Rd Essex

19. SEP 13 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1944, at 12.20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 28 1944, to Sept 12 1944
and that I last saw him alive on Sept 12 1944
Immediate cause of death Rheumatic Heart Disease — DURATION 1 Month
Due to .....
Due to .....
Other conditions .....
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE E R Eaden M.D. M. D. or other
Address 1 Libert Parkway Date signed 9-12-44

is especially important. Physicians: please write the causes of death clearly and legibly.

G20735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 137a

Registered No. G20735

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 20 S. Albemarle St. (If rural give location)
(e) Citizen of foreign country? Albemarle (or No) If yes, name country

3 (a) FULL NAME Alexander Kozak

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Anna Kozak.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years 61 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Laborer,

11. Industry or business

FATHER — 12. Name Unknown
13. Birthplace Russia

MOTHER — 14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Anna Kozak
(b) Address 20 S. Albemarle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18 1944 (month) (day) (year)
(c) Cemetery or crematory St Louis Cath Reposing
Location Cardiff Md.

18 (a) Funeral director Wendell F Hoppel
(b) Address 312 S. Highland Ave

SEP 19 1944 (Date received) (b) Hunting Williams Hall

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/8 1944, at 11:55 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Uremia

Due to

Other Conditions Hypertrophy Prostate

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Leigh B. Mitchell M.D. Medical Examiner.

Date signed 9/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20736

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √120a

G20736 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1y 5m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1201 Young Ct.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jernice Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 30, 1924

8. AGE: Years 19 | Months 9 | Days 11 | If less than one day hr. min.

9. Birthplace Danville, Va.
(Town, county, and state)

10. Usual Occupation Operator

11. Industry or business

FATHER 12. Name Nathaniel Wilson

13. Birthplace Danville, Va.

MOTHER 14. Maiden Name Ollie Wilson

15. Birthplace Danville, Va.

16 (a) Informant Ollie Wilson

(b) Address 1201 Young Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)

(c) Cemetery or crematory Cunningham

Location Danville, Va.

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Bl. Pantley Ave.

19 (a) (b) Huntington Williams, M.D.

SEP 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 19 44, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944, to Sept 11 1944, and that I last saw h. alive on Sept 11 19 44.

Immediate cause of death: Enterocolitis (Chronic)

Due to

Due to

Other Conditions Malnutrition, Leucocytosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. H. Banfield, M. D.

Address Provident Hospital Date signed 9/12/44

JL - 89 G20737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G20737
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Severn Savage

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Rosey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, ? 1887

8. AGE: Years	Months	Days	If less than one day
60 ?	? 3	? 12	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name George Savage
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (b) Date thereof Sept 15 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Balto. Md

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

SEP 13 1944 (b) Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1944 at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1944 to 9-11 1944 and that I last saw h.. alive on 9-11 1944.

Immediate cause of death Cerebral hemorrhage
middle cerebral artery
Due to H.C.V.D.
Due to
Other Conditions Gen. arterio-sclerosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Cerebral Hemorrhage

Duration
2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature E. L. Seipman M.D.
Address 13 C H Date signed 9/12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20738

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131 B

G20738 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 18

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 952 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn Catherine Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife: Thomas J. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1902

8. AGE: Years	Months	Days	If less than one day
42			hr. min.

9. Birthplace Md Annapolis (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hammond Hall
13. Birthplace Md

MOTHER
14. Maiden Name Jessie Brady
15. Birthplace Md

16 (a) Informant Thomas J. Smith
(b) Address 952 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14 44 (month) (day) (year)
(c) Cemetery or crematory Mass Western Ave
Location Baltimore Co. Md.

18 (a) Funeral director Mr. Katie R. Williams
(b) Address 322 N. Schroeder St

SEP 13 1944 (b) Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION 03

20. DATE OF DEATH Sept 11 1944, at 9 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1944 to Sept 11 1944, and that I last saw h[illegible] alive on Sept 11 1944.

Immediate cause of death: Chronic Nephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Campbell M. D.
Address Provident Hospital (Date signed) 9/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G20739

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1408 Myrtle Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1408 Myrtle Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Bennie Morris
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years 44 yrs | Months - | Days - | If less than one day hr. min.

9. Birthplace Middlesex Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William Morris
13. Birthplace Va.

MOTHER
14. Maiden Name Amanda Reid
15. Birthplace Va.

16 (a) Informant Clifton Morris
(b) Address 1764 Parkin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. E. Co. Md.

18 (a) Funeral director Chas. Alexander
(b) Address 927 N. Mount St.

19 (a) (Date received by registrar) (b) Registrar

VS: SEP 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1944, at 4:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1944 to Sept. 12 1944 and that I last saw h[illegible] alive on 9-12-1944

Immediate cause of death	Duration
Heart Failure	
Due to Hypertension	
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Julius S. White M.D.
Address 1543 Penn Date signed 9/13/44

G20740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1443

Registered No. G20740

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 7/31/44
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1809 Riggs Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME READ THURMAN WROTEN

3 (b) If veteran, name war: World War #2

3 (c) Social Security Account No. 218-01-9586

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 18, 1918

8. AGE: Years 25 | Months 5 9 | Days 24 2 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Salesman

11. Industry or business -

FATHER
12. Name James G. Wroten
13. Birthplace Dorchester Co.

MOTHER
14. Maiden Name Maggie Foxwell
15. Birthplace Dorchester Co.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT-14-44 (month) (day) (year)
(c) Cemetery or crematory LORDON PARK
Location Baltimore, Md.

18 (a) Funeral director F.B.WIPPERT'S SON
(b) Address 300 Eutaw Place

19 (a) (Date received by Registrar) SEP 13 1944 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH Sept. 11, 1944 at 8:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 31, 1944, to Sept. 11, 1944, and that I last saw him alive on Sept. 11, 1944

Immediate cause of death: Hodgkin's disease — Duration 8/1942

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations

of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify public place)
(e) Means of injury

23. Signature J. C. Archer, M.D.
Address Baltimore, Md. Date signed 9/12/44

Va-14532

G20741

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20741
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 42 S. Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Frederick Weitzel

3 (b) If veteran, name war	3 (c) Social Security Account No.
None.	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Hannah A. Weitzel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-70

8. AGE: Years	Months	Days	If less than one day
73	10	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Fredk Weitzel
13. Birthplace Md.

MOTHER
14. Maiden Name Georgianna Reynolds
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept. 15 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location O'Donnell St.

18 (a) Funeral director J. L. Mills
(b) Address 23 E. Jefferson St.

19 (a) Date rec'd by registrar SEP 13 1944 Signature Harrington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1944, at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944, to Sept 11 1944, and that I last saw him alive on Sept 11 1944.

Immediate cause of death	Duration
Acute Heart Failure	24 hrs.
Due to Hypertensive Cardiovascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. C. Cartwright M.D.
Address Johns Hopkins Hosp. Date signed 9-12-44

G20742 BALTIMORE CITY HEALTH DEPARTMENT G20742

460136 CERTIFICATE OF DEATH V14E Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. — (b) County
(c) City or town Portsmouth — (If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Parker Ave — (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Eleazer Atkins
3 (b) If veteran, name war —
3 (c) Social Security Account No. —
4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Virginia Walker
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-17-11
8. AGE: Years 33 | Months 11 | Days 25 | If less than one day hr. min.
9. Birthplace Va. — (Town, county, and state)
10. Usual Occupation Progressman
11. Industry or business Norfolk Navy Yard
FATHER 12. Name Eleazer Atkins
FATHER 13. Birthplace Va. —
MOTHER 14. Maiden Name Anna Johnston
MOTHER 15. Birthplace Va
16 (a) Informant Records —
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Rem. & Buried (Burial, cremation, or removal) (b) Date thereof 9/13/1944 (month) (day) (year)
(c) Cemetery or crematory Olive Branch
Location Portsmouth, Va.
18 (a) Funeral director Bizzell Funeral Home
(b) Address 3631 Holle Road
19 (a) (Date rec'd by) Huntington (b) Williams, MD Registrar

SEP 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1944 at 3:05 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2 1944 to Sept 12 1944 and that I last saw him alive on Sept. 12 1944
Immediate cause of death Hemorrhage into Pleural Cavity & Mediastinal Shift — Duration 20 days
Due to Cystic condition of lung — cause not determined — ?
Due to determined
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Laura Duchez, M.D.
Address Johns Hopkins Hosp. Signed 9/12/44

G20743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 136

G20743
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street.
(c) Hospital or institution:
South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1435 Cherry St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gottlieb H Stammer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frances Stammer
6 (c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): 1879
8. AGE: Years: 65 | Months: | Days: | If less than one day: hr. min.
9. Birthplace: Germany (Town, county and state)
10. Usual Occupation: Bricklayer
11. Industry or business:

FATHER
12. Name: Gottlieb Stammer
13. Birthplace: Germany

MOTHER
14. Maiden Name: Augusta Weise
15. Birthplace: Germany

16 (a) Informant: Frank Schultz
(b) Address: Masonville Md
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)
(c) Cemetery or crematory: Glen Haven
Location: Anne Arundel Co. Md
18 (a) Funeral director: Frank Brockhoff
(b) Address: 900 N. Chester St-5.
19 (a) SEP 13 1944 (Date rec'd by registrar) Huntington Williams Reg

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1944, at 3:05 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1944 to 9-11 1944, and that I last saw him alive on 9-11 1944.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 yr
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles R. MacDonald
Address 1213 Light St Date signed 9-11-44

VS 189

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

33200 $20744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$20744 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 1406 Ingraham Pl. N.W. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence Parsley III

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Clarence J. Parsley
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) 8-30-85

8. AGE: Years 59 | Months 0 | Days 13 | If less than one day hr. min.

9. Birthplace Washington DC. (Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name Edward Talbott
13. Birthplace (Md)

MOTHER 14. Maiden Name Mary Summerview
15. Birthplace (La)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)
(c) Cemetery or crematory Wash. D.C.
Location Wash. D.C.

18 (a) Funeral director Wm. R. Frank Hines
(b) Address 2261, 14th St. N.W. Washington, D.C.

1/5/1944 (Rec'd by registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13-1944 at 2.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11-1944 to 9-13-1944, and that I last saw her alive on 9-13-1944.

Immediate cause of death: Brain Tumor — Duration: 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-13-44
Major findings of operation: Brain Tumor
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Hugo V. Cargile M. D.
Address Johns Hopkins Hosp. Date signed 9-15-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20745 LENGAL 1860 G20745

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

City of Baltimore

Reg. Dist. No.

1. PLACE OF DEATH:
County O'Donnell Heights.
City or town Baltimore City.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo.
Hospital, institution, or street address where death occurred:
2b'
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County O'Donnell Hgts.
City or town Baltimore City.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1213 Cavendish Way.
(If rural, give LOCATION)
2.(a) If veteran, name war N

3. (a) FULL NAME Mary Lengal.

3. (b) Social Security Number None

4. Sex Fem.
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow.
6.(b) Name of husband or wife Michael.
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.) July 1, 1869
8. AGE: Years 75 Months 2 Days 11 If less than one day ____ hrs. ____ min.
9. Birthplace Czecho-Slovakia (Town, county, and state)
10. Usual occupation Waitress.
11. Industry or business None.
12. Name of FATHER Charles Haffinetz.
13. Birthplace Czecho-Slovakia.
14. Maiden name of MOTHER Mary
15. Birthplace
16. Interment Charles Pangel.
Address 121 3 Cavendish Way. Balto.
17. Disposal (Burial, cremation, or removal. Which?) Burial Date thereof 9/14/44 (month) (day) (year)
Cemetery or crematory Mt. Olivet New Salem Pa
Location New Salem Pa
16. Funeral director Wiseman Cook & Love
Address 127 E. Pratt St. Balto. Md.
18. SEP 14 1944 Registered Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1944, at 4:05 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 4 1944 to Sept 12 1944
and that I last saw h[illegible] alive on Sept 12 1944
Immediate cause of death
Cerebral Hemorrhage. — DURATION 9 days.
Due to Hemiplegia. —
Due to Paralysis st. site. — 3 days
Other conditions Fall down stairs.
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 9/3/44
Where did injury occur? Baltimore, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) At home.
Means of injury Fell down stairs Was injury at work? No.
23. SIGNATURE J. M. Carmichael M.D. (M. D. or other)
Address Overdale Md. 9/12/44

G20746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20746

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1916 Eutaw Place - D.O.A.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD - (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tyler B. Courtney

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-3899

4. Sex W.

5. Color or race M.

6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Elizabeth S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16th 1877

8. AGE: Years	Months	Days	If less than one day
67	4	26	hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation Paper Hanger

11. Industry or business Journeyman

FATHER
12. Name George Courtney
13. Birthplace Havre de Grace

MOTHER
14. Maiden Name Un Known
15. Birthplace Md.

16 (a) Informant Mrs F. M. Jones
(b) Address 836 Harford Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/44 (month) (day) (year)
(c) Cemetery or crematory St. Marys
Location Hamilden

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) SEP 14 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1944 at 5:35 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry-Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Chester F. Labrado M.D.
Medical Examiner.
Date signed 9/12/44

VS 151

C20747

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

Registered No. C20747

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure write the causes of death clearly and legibly. Physicians: please write age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 da
(e) Length of stay in Baltimore (yrs., mos., or days) 43

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Fairfield (If outside city or town limits, write RURAL and give town)
(d) Street No. 36 E. Trailer Court Camp (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lewis R. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 23rd 1944

8. AGE: Years	Months	Days	If less than one day
	2	19	hr. min.

9. Birthplace Fairfield Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Arden Johnson
13. Birthplace W. Va.

MOTHER
14. Maiden Name Mary A. Childers
15. Birthplace W. Va.

16 (a) Informant Arden Johnson
(b) Address E. 36th St. Fairfield Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/15/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director William Cook Jr.
(b) Address 1217 St. Paul St.

19 SEP 14 1944 (Date rec'd by registrar) [illegible] for Williamsport

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1944, at 11:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5-5 1944 to 9-12 1944, and that I last saw h/[illegible] alive on 9-12 1944.

Immediate cause of death	Duration
Malnutrition	
Due to Pyloric stenosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-10-44
Major findings of operation Pyloric stenosis
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles R. MacDonald M. D.
Address 1213 Light St Date signed 9-12-44

G20748 BALTIMORE CITY HEALTH DEPARTMENT G20748
Registered No.

CERTIFICATE OF DEATH 13 N

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 E. Hill St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 156 Hill St (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME John Zettlinger
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Hannah H.
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) Jan 13 - 76
8. AGE: Years 68 Months 7 Days 12 If less than one day hr. min.
9. Birthplace Maryland (Town, county, state)
10. Usual Occupation Undertaker
11. Industry or business Undertaker
FATHER 12. Name Geo. Conrad Zettlinger
13. Birthplace Germany
MOTHER 14. Maiden name Kitty Leibt.
15. Birthplace Germany
16 (a) Informant Wife — Mrs Zettlinger
(b) Address 156 E. Hill St. City
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14, 44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem.
Location Work Blvd & Jenny Rd.
18 (a) Funeral director John R Kenny
(b) Address 124 E Lynch Ter, Hamilton
19 (a) SEP 14 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 19 44, at 1:20 PM
21. I certify that death occurred on the date above stated; that I attended deceased from 9/ 19 44 to 9/12 19 44 and that I last saw h alive on 9/11 19 44.
Immediate cause of death Arteriosclerotic hypertensive cardiac renal disease
Due to cardiac Decompensation
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

Duration
7
7/28 hy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John P. Hagerman, Jr. M.D. M. D.
Address 1145 N Carey St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BI ING

VS 2

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20749 ✓ G20749

G20749

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No.

No. 487634

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos. 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2422 McCulloh St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Pollard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Mollie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1860

8. AGE: Years	Months	Days	If less than one day
83	8	13	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Old Age Pension
11. Industry or business

FATHER
12. Name Robert Pollard
13. Birthplace Virginia

MOTHER
14. Maiden Name Fannie Payne
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md.

18 (a) Funeral director Charles G.Cooper
(b) Address 512 N.Carrollton Ave

19 (a) (b) Huntington Mitty

SEP 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 10, 1944, at 8:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-25-44 19 to 9-10-44 19, and that I last saw h.m alive on 9-10-44 19

Immediate cause of death Hypertensive Cardio vascular disease
Due to Uremia

Due to

Other Conditions Gen. Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy

Duration
for 2 months

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Sangmann M.D.
Address 13 C H Date signed 9/11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20750 ✓ G20750 Registered No.

G20750 107

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 Hillen Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) all

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 510 Hillen Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lloyd, Mabel Elizabeth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Charles E. Lloyd

6 (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Oct 13. 1901

8. AGE: Years 42 | Months 11 | Days 29 | If less than one day ____ hr. ____ min.

9. Birthplace Carroll County (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Glover, M. Frank
13. Birthplace Carroll County

MOTHER
14. Maiden Name Stewart, V. Florence
15. Birthplace Baltimore Md

16 (a) Informant Charles E. Lloyd
(b) Address 510 Hillen Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 14-44 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial
Location Balto. Co.

18 (a) Funeral director A. A. Slade
(b) Address 4907 York Road

19 SEP 14 1944 (b) (Date received by Registrar) (Registrar's Address)

VS 150

MEDICAL CERTIFICATION. ✓

20. DATE OF DEATH Sept 11 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/17/44 19 to 9/11 19 44 and that I last saw h-- alive on 9/11/19 44

Immediate cause of death Acute Cardiac Dilatation — Duration 1 day

Due to

Due to

Other Conditions Arterio Sclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John E. Hansen M. D.
11 E. Chase St Date signed 9/14/44

G20751 ✓ G20751

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. ~~1600 Eutaw~~ 4972 Edgewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gene Wallace Mitunick

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/10/44

8. AGE: Years | Months | Days 3 da | If less than one day hr. min.

9. Birthplace Sinai Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Edward Mitunick
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Lillian Wenner
15. Birthplace Balto. Md

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)
(c) Cemetery or crematory Helen Friendship
Location Balto & Conkling Sts

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 RECD 1 6 1944 (Date received by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12/44 1944, to 9/13/44 19..., and that I last saw h alive on 9/13 1944.

Immediate cause of death: Intracranial Hemorrhage — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Intracranial Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature D. Price M. D.
Address Sinai Hosp. Date signed 9/15/44

G20752

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 C

Registered No. G20752

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 726 W. 23rd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Cortezi

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 1928

8. AGE: Years	Months	Days	If less than one day
16	2	13	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation school

11. Industry or business

FATHER
12. Name Samuel Cortezi
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Possidente
15. Birthplace Italy

16 (a) Informant Mrs Samuel Cortezi
(b) Address 426 West 23rd St.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 9-15-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leo Funk
(b) Address 5305 Harford Rd

19 (a) SEP 14 1944 (Date received by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12 1944, at 5:55 A.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Autopsy or Inquiry) thereon and from the evidence obtained by said Inquiry (Autopsy or Inquiry) find that said deceased came to natural death on the day stated above.

Immediate cause of death Fracture Dislocation of Spine — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N/2
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9-9-44 at 5:30 P.M.
(c) Where did injury occur? Howard St. bridge over Penn. R.R. tracks (Specific place) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public (Specify type of place) While at work? no
(e) Means of injury Pedestrian struck by auto

23. Signature Dwight B. Mitchell M.D. Medical Examiner.

Date signed 9/13/44

VS 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 934

G20753 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 934 Pierce St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 934 Pierce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J Tumes.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Alice

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 12-24-1894

8. AGE: Years 49 | Months 8 | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER 12. Name Thomas Tumes

13. Birthplace Md

MOTHER 14. Maiden Name Gertrude Peyner

15. Birthplace Va

16 (a) Informant Alice Tumes

(b) Address 934 Pierce St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem Cem

Location Arbutus Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, Registrar

SEP 14 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 9 1944 to Sept 9 1944 and that I last saw h[illegible] alive on Sept 9 1944

Immediate cause of death: Acute Myocarditis — Duration: Day

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 9-12-44

G20754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46b

Registered No. G20754

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1701 Ellamont ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Sperringhill ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Leish

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rebecca
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Mar 14 1876
8. AGE: Years 68 | Months 5 | Days 29 | If less than one day hr. min.
9. Birthplace: Russia (Town, county, and state)
10. Usual Occupation: Merchant
11. Industry or business

FATHER
12. Name: Frank Leish
13. Birthplace: Russia

MOTHER
14. Maiden Name: U.K.
15. Birthplace: Russia

16 (a) Informant: Frank Leish
(b) Address: 2805 Santafe ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 14 44 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Rodeph Sholem
Location: Bowley's Lane

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 124-26 W. North ave

19 SEP 14 1944 (Date rec'd by registrar) (b) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1944 9A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 19 to Sept 12 19 44
and that I last saw him alive on Sept 12 19 44
Immediate cause of death
(a) Carcinoma of Liver
(b) Stomach
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation June 6 / 44
Major findings of operation: Carcinoma of Liver & Stomach
Autopsy: No

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. L. Hornstein
Address 733 Ampitheatre Date signed 9/13/44 (M/D)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1354

Registered No. G20755

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 825 Whitelock St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 825 Whitelock St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris L. Moss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Fannie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name S. Bernard Moss
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Schless
15. Birthplace Russia

16 (a) Informant Beverly D. Moss
(b) Address 825 Whitelock St

17 (a) Burial (b) Date thereof Sept 14, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 SEP 14 1944 (b) [illegible] M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

5.40

20. DATE OF DEATH Sept 13, 1944, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11 1944, to Sept 13 1944
and that I last saw h[illegible] alive on Sept 12 1944.

Immediate cause of death	Duration
Uremia	1 wk.
Due to Urinary Retention	1 wk.
Due to Paralysis of Bladder "Cord Bladder"	10 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide [redacted]
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert Feldstone M. D.
Address 1113 Linden Av. Date signed 9/14

G20756

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14a

Registered No. G20756

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2404 Southern Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Southern Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Herman K. Ziemann

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-5770

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Dorothea C. Ziemann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25-1881

8. AGE: Years 62 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Grocery

FATHER
12. Name Karl Ziemann
13. Birthplace Germany

MOTHER
14. Maiden Name Wilhelmina Klat
15. Birthplace Germany

16 (a) Informant Mrs. John Velten
(b) Address 2404 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 15/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Lasahn Funeral Home
(b) Address 7401 Belair Road

SEP 14 1944
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12th. 1944, at 7.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1943 to Sept. 1944 and that I last saw h[illegible] alive on 9-12 1944

Immediate cause of death Myeloid Leukemia — Duration 2 years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Pegke M. D.
Address 4508 Harford Rd Date signed 9-12-44

VS 180

G20757

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20757

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 408 Murdock Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Gray Crowder

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Charles N. Crowder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1874

8. AGE: Years 70 | Months 2 | Days 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Walter Gray
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Sapp
15. Birthplace Baltimore

16 (a) Informant Mrs. Ailsa C. Mathers
(b) Address 408 Murdock Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell Undertaking Co., Inc.
(b) Address 1900 Eutaw Place

19 (a) SEP 14 1944 (Date received by registrar) Huntington Williams, M.D. Registrar
(b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13 1944, at 1/35 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 2nd 1944 to Sept. 13 1944
and that I last saw h.er alive on Sept. 12 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 7 days
Due to Arteriosclerosis — Duration: Some years
Due to Hypertension — Duration: yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clark H. Benson, M.D.
M. D.
Address 5111 York Road Date signed 9/13/44

G20758 N. ers

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

940 Registered No. G20758

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens Ave.
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 St. Charles Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lola E Ellstrom

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Peter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27, 1882

8. AGE: Years	Months	Days	If less than one day
61 60	8	14	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name John Bodlman
13. Birthplace Virginia

MOTHER 14. Maiden Name Laura Hubbard
15. Birthplace Balto. Md

16 (a) Informant Mr. Peter Ellstrom
(b) Address 1010 St Charles Ave.

17 (a) Burial (b) Date thereof 9-14-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A Applegarth
(b) Address 4101 Edmondson Ave

SEP 14 1944
(a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/11 1944, at 11:40 P.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to natural death on the day stated above.
(Autopsy or Inquiry) (Autopsy or Inquiry)

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh B. Mitchell M.D.
Medical Examiner.
Date signed 9/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20759 BALTIMORE CITY HEALTH DEPARTMENT G20759

CERTIFICATE OF DEATH 47a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3808 Harlem Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3808 Harlem Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BERNARD L. LINGERMAN Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife late Mary J. Ware

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30, 1864

8. AGE: Years 79 | Months 8 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Stone cutter

FATHER 12. Name Henry Lingerman

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Schanefelter

15. Birthplace

16 (a) Informant Bernard L. Lingerman

(b) Address 3808 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.16.44. (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Woodlawn Md.

18 (a) Funeral director Harry H. Wilzke

(b) Address 4101 E Monument Ave.

19 (a) SEP 14 1944 [illegible]

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 19 44, at 9 a.m. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma of lungs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. J. Wollenweber M.D. Medical Examiner.

Date signed Sept 13, 1944

G20760

BALTIMORE CITY HEALTH DEPARTMENT 61

CERTIFICATE OF DEATH G20760

Registered No. _____

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. & John Street
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Baltimore (b) County Baltimore
(c) City or town _____ (If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Garrison Boulevard (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3 (a) FULL NAME Mary Theresa Rafferty
3 (b) If veteran, name war _____
3 (c) Social Security Account No. _____

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: late Bartholomew Rafferty
6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Feb. 13 1865

8. AGE: Years 79 | Months 7 6 | Days 29 | If less than one day _____ hr. _____ min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation House wife

11. Industry or business Home

FATHER
12. Name Patrick Raffy
13. Birthplace Ireland

MOTHER
14. Maiden Name ~~Murphy~~ Murphy
15. Birthplace Ireland

16 (a) Informant J. Bernard Rafferty
(b) Address 4013 Woodridge Road, Balto. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9. 16. 44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3900 Old Frederick Rd.

18 (a) Funeral director Harry A. Witzke
(b) Address 4101 E. Monument Ave.

19 (a) _____ (Date rec'd by registrar) (b) _____ Registrar

SEP 14 1944

Carrington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1944 at 2 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from September 1 1944 to Sept. 12 1944 and that I last saw her alive on Sept. 12 1944.

	Duration
Immediate cause of death: Diabetic coma	12 hours
Due to: Diabetes mellitus	10 years
Due to:	
Other Conditions: Generalized arterio-sclerosis (Include pregnancy within 3 months of death)	

Date of operation None
Major findings of operation: _____
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Marjorie Lewisohn
Address Hosp. for Women of Md. Date signed M. 9 D. 12/44

G20761

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93 N

G20761
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 West 40th St
(c) Hospital or institution:
Home for Incurables -
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs. 1 mo 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary M. Lucas.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed -
6 (b) Name of husband or wife: Lewis F. Lucas -
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/30/1857
8. AGE: Years 86 | Months 11 | Days 12 | If less than one day hr. min.
9. Birthplace Philadelphia - Pa (town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James K. Rogers —
13. Birthplace England -

MOTHER
14. Maiden Name Amelia Frances Mann.
15. Birthplace England -

16 (a) Informant H. LaRue Browning
(b) Address 700 W. 40th St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Rd.
18 (a) Funeral director John D. Mitchell & Son
(b) Address 1900 Eutaw Place
19 (a) (Date received) SEP 14 1944 (b) Registrar [illegible] Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12/1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1942 to Sept 12 1944, and that I last saw h[illegible] alive on Sept 11 1944.

Immediate cause of death: Congestive Heart Failure — Duration: 1 month +
Due to: Hypertensive Cardio Vascular Disease — Duration: Many Years
Due to: — Duration:
Other Conditions: Arteriosclerosis — Duration: 12 yrs
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Command M.D.
Address 11 E. Chase St Baltimore, Maryland
Date signed 9/13/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FOR BINDING

MARYLAND RESERVED FOR HEADING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1519 G20768

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6da
(e) Length of stay in Baltimore (yrs., mos., or days) 4 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1127 Whatcoat st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Fenwick

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/30/44

8. AGE: Years	Months	Days	If less than one day
	4	13	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Asbery Hopewell
13. Birthplace Md

MOTHER
14. Maiden Name Anna Fenwick
15. Birthplace Md

16 (a) Informant Anna Francis
(b) Address 1127 Whatcoat st.

17 (a) Burial (b) Date thereof 9-15-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Pettis cem.
Location

18 (a) Funeral director George A. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) (b)

Date rec'd SEP 14 1944 Huntington-Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1944, at 4 40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1944, to 9-13 1944, and that I last saw him alive on 9-12 1944.

Immediate cause of death Dehydration

Due to hyperemesis

Due to pylorospasm

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Lynn M. D.
Address University Hospital Date signed 9-12-44

G20763

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 50

Registered No. G20763

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & Johns St.
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County Clinton
(c) City or town Jinnaghoning (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Elyna Sliker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife Charles Wesley Sliker
6 (c) If alive, give age 76 years
7. Birth date of deceased (mo., day, yr.) 11 30 1866

8. AGE: Years	Months	Days	If less than one day
83	9	14	3 hr. ..... min.

9. Birthplace Hammersley, Pa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hicks
13. Birthplace Hammersley Fork Pa

MOTHER
14. Maiden Name Mary Wyckoff
15. Birthplace Hammersley Fork Pa

16 (a) Informant Clair Winkelhofer
(b) Address

17 (a) Burial (b) Date thereof Sept 15 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wolf Burd, Pa

18 (a) Funeral director J. Heneman & Son
(b) Address 32 S Broadway
(Date received by Registrar) SEP 14 1944 (b) Registrar Huntington Williams

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/13/1944, at 3:15 M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/10/1944 to 9/13/1944, and that I last saw her alive on 9/11/1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Radical Mastectomy Right (Include pregnancy within 3 months of death)	

Date of operation 9/12/44
Major findings of operation: Carcinoma Breast and
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Felix Guttadauro
Address Women's Hospital Signed 9/13/44 (M. D.)

G20764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G20764

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 S. Woodyear St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Woodyear St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry L. Schmidt

3 (b) If veteran, name war ----

3 (c) Social Security Account No. 714-05-6645

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth G. Schmidt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 20, 1883

8. AGE: Years	Months	Days	If less than one day
60	9	23	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Routeman
11. Industry or business Railway Express Agency, Inc.

FATHER
12. Name John Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Mainz
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth G. Schmidt
(b) Address 309 S. Woodyear St.,

17 (a) Burial (b) Date thereof Sept. 16, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3207 W. North Ave.,

SEP 14 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1944, at 8.00 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1944 to 9/12 1944, and that I last saw alive on 9/12 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	(7)
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas E. Bogard M. D.
Address 1054 Bolton St. Date signed 9/13/44

G20765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 123

Registered No. G20765

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Catonsville
(c) Hospital or institution: St Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 S. Parrish St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George H. Meile
3 (b) If veteran, name war NONE
3 (c) Social Security Account No. 218-09-8742

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife Lula S.
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) July 28-1884

8. AGE: Years 60 | Months 1 | Days 15 | If less than one day ✓ hr. min.

9. Birthplace Md. Baltimore (Town, county, and state)
10. Usual Occupation BUTCHER
11. Industry or business SLAUGHTER HOUSE.

FATHER
12. Name GEORGE H. MEILE
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name MARGARET HINK
15. Birthplace BALTIMORE, MD.

16 (a) Informant J. Solms
(b) Address St. Agnes Hospital

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT-15-44 (month) (day) (year)
(c) Cemetery or crematory MOUNT OLIVET
Location FREDERICK AVENUE.

18 (a) Funeral director C. RAYMOND KAUFMAN
(b) Address 1076 LEEDS AVENUE.

SEP 14 1944 (Date received by Registrar) Hampton Williams MD Registrar

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH 9-12 1944 at 6:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1944 to 9-12 1944 and that I last saw h. alive on 9-12 1944.

Immediate cause of death Peripheral Vascular Collapse — Duration
Due to Pelvic Cellulitis
Due to Peri-rectal Abscess
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Pelvic Cellulitis
of autopsy: Peri-rectal Abscess

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H E McGrath M.D. M. D.
Address St Agnes Hosp. Date signed 9-12-44

G20766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G20766

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 230 South Broadway
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days) 50yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 230 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Vanmeter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife John Vanmeter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/70

8. AGE: Years	Months	Days	If less than one day
74	0	27	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name Patrick Harney
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Fitzpatrick
15. Birthplace Ireland

16 (a) Informant Elizabeth Freeburger (sis)
(b) Address 3004 E. Pratt Street

17 (a) Burial (b) Date thereof 9/15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Harford Road

18 (a) Funeral director Ally-Fisher Fun.
(b) Address 403 S. Wolfe Street

SEP 14 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/12/44 M, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/x 6 1944, to 9/12 1944, and that I last saw h[illegible] alive on 9/11 1944.

Immediate cause of death Chronic Myocarditis — Cardiac Hypertrophy — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph Lantry M.D.
Address 446 S. Ellwood Av Date signed 9/13/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 G20267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3532 Elmley
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 3532 Elmley Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John V. A. Leary

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-4471

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Frieda A. Leary

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Jan 26-1884

8. AGE: Years	Months	Days	If less than one day
60	7	16	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Chauffer

11. Industry or business

FATHER
12. Name Thos J. A. Leary
13. Birthplace Baltimore

MOTHER
14. Maiden Name Hannah Finn
15. Birthplace Baltimore

16 (a) Informant Mrs Frida A Leary

(b) Address 3532 Elmley ave

17 (a) Burial (b) Date thereof Sept 15/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem. City

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2014 E. Oriole St

19 (a) SEP 1 1944 (b) Huntington Maryland
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12th 1944, at 12:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 5 1944 to Sept 12 1944, and that I last saw him alive on Sept 12 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration 7 days

Due to: Carcinoma of Stomach — Duration 4 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Rosner M. D.

Address 8014 Kenwood Ave Date signed Sept 13 1944

G20768

JO #89580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 N

G20768 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 Estelle St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Frank H. Baker

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-10-3161

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Viola

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 10, 1896

8. AGE: Years 48 | Months 4 | Days 1 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, or state)

10. Usual Occupation Sheet mill Fireman

11. Industry or business Bath. Steel

12. Name of FATHER: William Baker

13. Birthplace of FATHER: Maryland

14. Maiden Name of MOTHER: Louise Myer

15. Birthplace of MOTHER: Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 14-44 (month) (day) (year)

(c) Cemetery or crematory Maryland Park

Location Taylor Ave.

18 (a) Funeral director John B. Connally

(b) Address Govans, Md.

19 (a) (Date received by Local Registrar) SEP 14 1944 Registrar

VS 168

MEDICAL CERTIFICATION

20. DATE OF DEATH September 11, 1944, 5:50A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/30 1944 to 9/11 1944 and that I last saw h alive on 9/11 1944

Immediate cause of death

Coronary occlusion

Duration 12 da.

Due to

Due to

Other Conditions Hypertension Cardio sclerosis

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify home, farm, etc.)

(e) Means of injury

23. Signature C. A. Parry Jr.

Address City Hosp. Date signed 9-11

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G20769 Registered No.

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 426 N Luzerne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 426 N Luzerne Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie A. Gabriel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frederick J. Gabriel

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years abt. 57 | Months - | Days - | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Byrne
13. Birthplace Ireland

MOTHER
14. Maiden Name Gahnan
15. Birthplace Ireland

16 (a) Informant Mr. F. J. Gabriel
(b) Address 426 N Luzerne Ave

17 (a) Burial, cremation, or removal Burial (b) Date thereof 9/16/44 (month) (day) (year)

(c) Cemetery or crematory Catholic
Location Baltimore

18 (a) Funeral director Tobey & Sons
(b) Address 1318 Light St.

SEP 14 1944
(Date rec'd by registrar)

Harrington Williams, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1944 at 9 hr. M

21. I certify that death occurred on the date above stated, that I attended deceased from [illegible] 1944, and that I last saw h[illegible] alive on [illegible] 1944.

Immediate cause of death	Duration
Cerebral Vascular Sclerosis	1 year
Due to Arterio-Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph L. Valentine M.D.
Address 1532 N Howard St Date signed 9/16/44

G20770

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

G20770 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S. Hanover St-30 (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Carroll Petrovich

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-17-43
8. AGE: Years 10 Months Days 27 If less than one day hr. min.
9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Petrovich
13. Birthplace Md. Pa.

MOTHER
14. Maiden Name Georgia Judy
15. Birthplace Md. N. Dak

16 (a) Informant Mrs Petrovich
(b) Address 719 S Hanover
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Ritchie Highway
18 (a) Funeral director J. J. Tobey Home
(b) Address 1218 Light St.
19 (a) (Signature of registrar) (b) Huntington Williams, M.D. Registrar

SEP 14 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1944, at 9A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6 1944 to 9/14 1944 and that I last saw [illegible] alive on 9/14 1944

Immediate cause of death: Collapse — Duration: ____

Due to: Severe Anemia and nutritional Edema — Duration: 2 mo

Due to: Malnutrition due to poor dietary venture

Other conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J Bryan M. D.
Address St. Agnes Hosp. Date signed 9/14/44

G20771

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20771 Registered No. 169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D.O.A. Sixth Balt. Co. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Somerset
(c) City or town Rural Dames Quarter Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Webster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Dead

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months — | Days — | If less than one day hr. min.

9. Birthplace Dames Quarter Md (Town, county, and state)

10. Usual Occupation Retired Waterman

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Dames Quarter

MOTHER 14. Maiden Name Unknown

15. Birthplace Dames Quarter

16 (a) Informant Gladys Bozman

(b) Address Dames Quarter Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 16 (month) (day) (year)

(c) Cemetery or crematory Dames Quarter Md

Location Somerset Co

18 (a) Funeral director Fred A Forby

(b) Address Fairmont & Fayette Sts

SEP 14 1944 (Date rec'd by reg'r) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12 1944, at 11 00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull - Multiple Fractures and internal injuries

Due to Struck by train while walking along tracks

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 9/12/44 at 10 22 A.M. 21/1

(b) Where did injury occur? Scott St and Bad Railroad

(c) Did injury occur at home, on farm, industrial place, in public place? Railroad While at work?

(d) Means of injury

23. Signature Chester J. Sulanke M.D. Medical Examiner.

Date signed 9/12/44

G20772

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20772 Registered No. 48 B

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Type is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Blk. E. Monument
(c) Hospital or institution: Sinai Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2906 Rockrose ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Hankin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Abraham

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 49 | Months | Days | If less than one day: hr. min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name John Berman
13. Birthplace Russia

MOTHER
14. Maiden Name Dora Brauer
15. Birthplace Russia

16 (a) Informant Mrs Lena Rothkind
(b) Address 2802 Norfolk ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15 44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Rowdale
Location Hamilton Ave & Philia Rd

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W. North ave

19 (a) (b)

SEP 14 1944 (Date registered) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1944, at 6 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1944, to 9/14 1944, and that I last saw her alive on 9/14 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Intestinal obstruction	
Due to Carcinoma, abdominal	over
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Abram M. D.
Address Sinai Hosp. Date signed 9/14/44

G20773

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G20773

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3500 6th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-5
(e) Length of stay in Baltimore (yrs., mos., or days) 53yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. City.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1624 Cereal St. Curtis Bay
(If rural give location)
(e) If foreign born, how long in U. S. A.? 53 years

3 (a) FULL NAME Katherine Marcus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Michael Marcus

6 (c) If alive, give age 87 years

7. Birth date of deceased (mo., day, yr.) Nov. 25 1862

8. AGE: Years 81 | Months 9 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Vsenia Austria
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Michael Estaka
13. Birthplace Austria

MOTHER
14. Maiden Name Madeline Estaka
15. Birthplace Austrian

16 (a) Informant John M. Marcus

(b) Address 3901 5th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Frederick Road

18 (a) Funeral director Clarence W. Brown

(b) Address 3615-17 Harford Ave

19 (a) SEP 15 1944 (b) Filed Sept. 15 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1944 at 9 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 5 1944 to Nov. 12 1944, and that I last saw h.e.r. alive on Sept 12 1944.

Immediate cause of death Carcinoma of Colon.

Duration 6 Wks.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature P. J. Arnaldi M. D.

Address 4609 Fr. Ritchie Date signed 9-12-44

VS 3

C620774 ✓ C620774

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Filbert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Zukaitis (Zukauskus)

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex Female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ignatz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Ignatz Zukaitis
(b) Address 1615 Filbert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16 44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cem.
Location Glendale, Md.

18 (a) Funeral director Joseph Kasunskas
(b) Address 2 Washington Blvd
(c) SEP 15 1944
(d) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-12 1944 at 6.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-11 1944 to 9-12 1944, and that I last saw h alive on 9-12 1944

Immediate cause of death: Hypertensive cardiovascular disease

Duration

Due to: Chronic nephritis.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles P. McDonnell M. D.
Address 1213 Light St Date signed Sept 15 44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly.

G20775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G20775

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4109 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-9
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Norfolk Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Max H. Nathanson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Poth (Town, county, and state)

10. Usual Occupation Dealer

11. Industry or business Fats + Tallow

FATHER
12. Name Abraham Nathanson
13. Birthplace Poth

MOTHER
14. Maiden Name Hannah-
15. Birthplace Poth

16 (a) Informant Pauline Nathanson
(b) Address 4109 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-44 (month) (day) (year)
(c) Cemetery or crematory Beth Shalom
Location Windsor Mill Rd.

18 (a) Funeral director Jack Levine Inc
(b) Address 1439 E. Balto. St.

19 (a) SEP 15 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1944 at 8:50 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D.
Medical Examiner.
Date signed Sept 14 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56E

Registered No. G20776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address MONUMENT ST.
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

15-11

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 3525 LYNCHESTER RD (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME marcus Orlove

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. 110-05-9076

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	WHITE	MARRIED

6 (b) Name of husband or wife SYLVIA
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1903

8. AGE: Years	Months	Days	If less than one day
41			hr. min.

9. Birthplace LONDON (Town, county, and state)
10. Usual Occupation TRAVELING SALESMAN
11. Industry or business

FATHER
12. Name MORRIS
13. Birthplace RUSSIA

MOTHER
14. Maiden Name DORA
15. Birthplace RUSSIA

16 (a) Informant HOSPT. RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-17-44 (month) (day) (year)
(c) Cemetery or crematory BETH TFILOH
Location WINDSOR MILL RD
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E Balto St.
SEP 15 1944 Huntington Williams M.P.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1944, at 2.35 AM
21. I certify that death occurred on the date above stated; that I attended deceased from 8/23 1944 to 9/14 1944, and that I last saw him alive on 9/14 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Lipoplasia-Granulomatosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Marks M.D.
Address Sinai Hosp Date signed 9/17/44

VS 150

G20777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G20777

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson Ave & Dukeland St.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits write RURAL and give town)
5-4
(d) Street No. 2301 N. Pulaski St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Eisenberg (Eisenberg)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Max
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1880
8. AGE: Years 64 | Months 1 | Days | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Abraham Krieger
13. Birthplace Poland

MOTHER
14. Maiden Name Sarah -
15. Birthplace Poland

16 (a) Informant Harry Jacobs
(b) Address 2301 N. Pulaski St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-44 (month) (day) (year)
(c) Cemetery or crematory United Hebrew
Location Wash. Blvd.
18 (a) Funeral director Jacob Levine Inc
(b) Address 1439 E. Balto. St.

SEP 15 1944 (Date of acceptance by Registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1944, at 1:00 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1944 to 9/14 1944, and that I last saw h[illegible] alive on 9/14 1944.

Immediate cause of death	Duration
Myocardial failure	
Due to Pneu. bronchial	1 day
Due to Pulmonary edema (contributory)	1 day
Other Conditions Diabetes mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Irving Stapleton M.D.
Address WBGH Date signed 9/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G20778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G20778

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden Ave & Hendler Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give county)
(d) Street No. Georgian Court Apts (If rural give location)
Linden & Belvedere
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Morris Mannheimer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace U. S. A. (Town, county, and state)

10. Usual Occupation Pharmacist

11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Germany

MOTHER
14. Maiden Name Rachael
15. Birthplace Germany

16 (a) Informant Raymond Mannheimer
(b) Address Georgian Court Apts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-15-44 (month) (day) (year)
(c) Cemetery or crematory Ohel Shalom
Location Old Pimlico Rd

18 (a) Funeral director Jacob Levin Inc
(b) Address 1459 E Baltimore St

19 (a) (Signature) (b) Huntington Williams, M.D. Registrar

SEP 15 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1930, to Sept 14 1944, and that I last saw h[illegible] alive on Sept 14 1944.

Immediate cause of death Lung metastasis (Carcinoma) Coronary failure — Duration 10 yrs

Due to Arteriosclerosis — Duration 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide [redacted]
(b) Date of occurrence [redacted] at [redacted] M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. F. Yeager M.D.
Address Glenwood Date signed 9/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20779

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 108

G20779 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 W. Lanvale
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 W. Lanvale (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Martha Perkins Perkins

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	C	Widow

6 (b) Name of husband or wife William Perkins
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1907

8. AGE: Years	Months	Days	If less than one day
37	4	?	hr. min.

9. Birthplace Alexandria Va.
(Town, county, and state)
10. Usual Occupation Janitress
11. Industry or business

FATHER
12. Name Mercer Hunter
13. Birthplace Middleburg Va

MOTHER
14. Maiden Name Rose Taylor
15. Birthplace Culpeper Co. Va.

16 (a) Informant Mattie Sands
(b) Address 1620 W. Lanvale

17 (a) Burial (b) Date thereof Sept 16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. Co. Md

18 (a) Funeral director Mrs Katie R Williams
(b) Address 320 N Schroeder St

SEP 15 1944 Washington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 13 1944 2:27 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1944 to Sept 13 1944 and that I last saw h-- alive on Sept 13 1944.

Immediate cause of death	Duration
(a) Acute Myocarditis Pulmonary edema	2 Days 1 Day
Due to (b) Lobar Pneumonia	9 days
Due to (c)	
Other Conditions Arthritis	1 week

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Coca de Loy Berry M. D.
Address 1420 E. Chase Date signed 9-14-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARG... RESERVED FOR BI...ING

G20780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 123

Registered No. G20780

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Edward & Gum Sts. 18
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 524 N Shroeder St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** James Wright

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col.	W

6 (b) Name of husband or wife Mary D Wright
Died 1938 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Appomattox, Virginia (Town, county, and state)
10. Usual Occupation Shipping Clerk.
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Mrs Geraldine D. Wright
(b) Address 524 No Schroeder St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16-44 (month) (day) (year)
(c) Cemetery or crematory Md. Zion Cem
Location Bolts to Bel

18 (a) Funeral director Mrs Kate L Williams
(b) Address 322 N Schroeder St

19 SEP 15 1944 (Date received by Registrar) (b) Filed by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1944 at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944 to Sept 13 1944, and that I last saw him alive on Sept 13 1944

Immediate cause of death Uremia

Due to Cachexia from fistula from colon to abdomen

Due to Intestinal obstruction due to Post operative adhesions

Other Conditions Arteriosclerotic cardiovascular disease

(Include pregnancy within 3 months of death)

Date of operation 8/3 and 8/29

Major findings of operation: Multiple adhesions

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature LeRoy W Tilt
Address University Hosp. Date signed 9/13/44 M. D.
LeRoy W. Tilt, M.D.

G20781 488 845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

44a

Registered No. G20781

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not guess at any item. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address John Hopkins Hospital

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 2

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1140 Eastern St

(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Ella Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Taft Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-7-15

8. AGE: Years 29. Months 6 Days 5 If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Henry James

13. Birthplace Va

MOTHER

14. Maiden Name Cinnie Nattnaniel

15. Birthplace Va

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 19 44 (month) (day) (year)

(c) Cemetery or crematory Ashley

Location Louisa Co. Va

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 2227 Schroeder St

19 (a) SEP 15 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1944, at 11.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from August 8 1944, to Sept 12 1944, and that I last saw h[illegible] alive on Sept 12 1944

Immediate cause of death: Cachexia & malnutrition — Duration 1 yr

Due to: Plastic peritonitis due to ? adenoma inguinale

Due to: ? tuberculosis

Other Conditions: Lymphopathia Venerum

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Abraham Cantor M. D.

Address 9-12-44 Johns Hopkins Hospital Date signed

G20782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G20782

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 Jackson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Disney

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Marg. Havickhorst
6 (c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) May 12 1884

8. AGE: Years 60 | Months 4 | Days - | If less than one day: hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Wm. T. Disney
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Dudrol
15. Birthplace Unknown

16 (a) Informant Mrs. Henry Brotschneider
(b) Address 1107 N. Patterson Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 15, 44 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St.

18 (a) Funeral director L. Hermann & Son
(b) Address 32 S. Broadway

19 (a) SEP 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1944, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fractured Skull
Due to Acute Alcoholism.
Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-12-44 at 1:30 P.M.
(b) Where did injury occur? In front of 1720 E. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Fell to pavement from Acute Alcoholism.

23. Signature H. W. Williams M.D.
Medical Examiner.
Date signed September 13, 1944.

VS 151

G20753

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G20783
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 N. Carrollton Ave.
(c) Hospital or institution:
N. M. Carroll Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 N. Carrollton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Duke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1867

8. AGE: Years 77 | Months 75 | Days 2 | If less than one day 11/0 hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Benjamin Jones
13. Birthplace Va.

MOTHER
14. Maiden Name Harriett ?
15. Birthplace Va.

16 (a) Informant Miss Rosa Stewart
(b) Address 822 N. Carrollton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

SEP 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, '44 (day) at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1944 to Sept 12 1944, and that I last saw h[illegible] alive on Sept 12 '44.

Immediate cause of death: Congestive Heart Failure

Due to: Hypertension Cardiac Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 1 month

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Rackley, M.D.

Address 426 N. Johns Date signed 9/13/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FOR BI[illegible]ING

G20784

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1480

Registered No. G20784

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St. 16
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3925 Colborne Road (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth Noe G 9458 9459

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James Noe [redacted]

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1918

8. AGE: Years 26 | Months 7 | Days 5 | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Naylor Weber
13. Birthplace Va.

MOTHER
14. Maiden Name Daisy Perry
15. Birthplace Va.

16 (a) Informant Mr. James. N. Noe
(b) Address 3925 Colborne Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/15/44 (month) (day) (year)
(c) Cemetery or crematory
Location Washington, D. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received SEP 15 1944 (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15 1944, at 12 07 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1944 to 9-15 1944, and that I last saw h[illegible] alive on 9-13 1944.

Immediate cause of death: Prolonged Pre-eclampsia — Duration: 3 wks.
Due to:
Due to:
Other Conditions: Vascular Shock. — over

(Include pregnancy within 3 months of death)
Date of operation 9-14-44 Caesarean Section
Major findings of operation: Uterus pregnancy - tumors
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles R. Ingersoll M. D.
Address 1213 Light St. Date signed 9-15-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

G20785

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163 H

G20785 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5703 Harford Rd
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5703 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE FRIEDH EURICH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	White	Widow

6 (b) Name of husband or wife William E. Eurich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1865

8. AGE: Years	Months	Days	If less than one day
79	0	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Kohler
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mr. Benjamin H. Kaiss
(b) Address 3944 Dolfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 16- 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc
(b) Address North Ave. & Broadway- 13

19 SEP 15 1944 Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 13, 1944, at 6:12 P. M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-13-44 6 P. M.
(b) Where did injury occur? 5703 Harford Rd
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No.
(d) Means of injury kitchen flame

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.
Date signed Sept 13, 1944.

G20786 BALTIMORE CITY HEALTH DEPARTMENT G20786

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (Ridgewood)
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1004 Beechfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDNA LOUISA SCHUBERT

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Nicholas Schubert

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 20, 1865

8. AGE: Years 79 | Months 3 | Days 24 | If less than one day: hr. min.

9. Birthplace: Kingsville, Md (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business:

FATHER
12. Name: Alexander Moore
13. Birthplace: Kingsville, Md

MOTHER
14. Maiden Name: Mary Ann Schaeffer
15. Birthplace: Kingsville, Md

16 (a) Informant: Mr. Geo. W. Schubert
(b) Address: Catonsville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-13-44 (month) (day) (year)
(c) Cemetery or crematory: St. Johns Cemetery
Location: Kingsville, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 SEP 15 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13-44 19..., at 5:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11-44 19... to 9-13-44 19... and that I last saw her alive on 9-13-44 19...

Immediate cause of death	Duration
Toxemia	
Due to Gangrene of right leg	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature Frank L Vannie M. D.
Address St. Joseph's Hosp. Date signed 9-13-44

G20787 BALTIMORE CITY HEALTH DEPARTMENT G20787

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloma Av
(c) Hospital or institution: Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 508 E. 42 St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith R. Nelson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 3 1871

8. AGE: Years 73 | Months | Days 11 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER — 12. Name George Nelson
13. Birthplace Md.

MOTHER — 14. Maiden Name Georgia Nelson
15. Birthplace Md.

16 (a) Informant Bertha Bowers
(b) Address 508 E. 42 St

17 (a) Burial (b) Date thereof Sept 16 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.

18 (a) Funeral director Chas. O. Sherman
(b) Address 4701 Harford Rd

19 (a) (Date received by registrar) SEP 15 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1944 at 8P M

21. I certify that death occurred on the date above stated, that attended deceased from Sept 7 1944 to Sept 14 1944
and that I last saw h[illegible] alive on Sept 14 1944

Immediate cause of death, Cerebral Hemorrhage — Duration Mos

Due to — Duration

Due to — Duration

Other Conditions Arteriosclerosis Coronary Thrombosis — Duration yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. A. Grahnder M.D.
Address 1120 N. Charles St Date signed Sept 16 44

G20788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G20788

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. Every item of information should be correct as is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 132 N. Luzerne Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 N. Luzerne Av (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret M. Zamrzla

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles A.

6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) June 1 - 1869

8. AGE: Years 75 | Months 3 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Frederick Wm. Koch
13. Birthplace Ger. York

MOTHER
14. Maiden Name Zensia
15. Birthplace Germany

16 (a) Informant Charles A. Zamrzla
(b) Address 32 N. Luzerne Av

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rood Cem.
Location Beech Road.

18 (a) Funeral director John A. McGann
(b) Address 3008 E. Baltimore St. (Name of Manager or Nathaniel Mgr.)

19 (a) (b) Registrar
(Date filed in registry)
SEP 15 1944
VS 119

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1944, at 2 55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944 to Sept 13 1944, and that I last saw h[er] alive on Sept 13 1944

Immediate cause of death	Duration
Due to Cerebral Hemorrhage	9/10/44
Due to Chr. Myocard. I.	1944
Other Conditions Arteriosclerosis	1942

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Ryan, M.D.

Address 8014 Kenwood Av Date signed 9/14/44

G20789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20789 Registered No. 131a (new)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3803 1/2 Copely Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 33 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3803 1/2 Copely Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Moreland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Julius

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER

12. Name Hyman L. —

13. Birthplace Russia

14. Maiden Name Etta —

15. Birthplace Russia

16 (a) Informant Mrs. Anna Levy

(b) Address 3803 1/2 Copely Rd 9-15-44

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location

18 (a) Funeral director Jack Feiss & Son

(b) Address 1439 E. Balto. St

19 SEP 15 1944 (Date received by Registrar) By Huntington Williams Asst. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept - 15 - 1944, at 11 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-5-1944 to Sept-15-1944 and that I last saw him alive on Sept-15-1944.

Immediate cause of death: Cardiac-failure — Duration: about 5 days

Due to arterio-sclerosis

Due to Hypertension

Other Conditions chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Herman Seidel

Address 2404 Eutaw Pl Date signed 9/15/44 D.

Gutflersoh

G20790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

Registered No. G20790

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Maryland Road
(c) Hospital or institution: Sydenham Hosp: Yale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3716 Northern Parkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Gutfleisch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5th 1934

8. AGE: Years	Months	Days	If less than one day
10	3	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Scholar

11. Industry or business

FATHER
12. Name Michael Gutfleisch
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Miller
15. Birthplace Baltimore Md.

16 (a) Informant Margaret Gutfleisch
(b) Address 3716 Northern Parkway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Parkville Maryland

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Road

19 (a) SEP 15 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944, to Sept 14 1944, and that I last saw him alive on Sept 14 1944.

Immediate cause of death	Duration
Lobar Pneumonia	
Toxemia	22 days
Due to Pneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret N. D. Smith M. D.
Address Sydenham Hosp Date signed 9-14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G20791

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3325 St. Paul St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3325 St. Paul
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Jenkins

3 (b) If veteran, name war

3 (c) Social Security Account No. 238-18-5221

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/19/1895

8. AGE: Years	Months	Days	If less than one day
49 50	0	25	hr. min.

9. Birthplace Lincolnton, N.C.
(Town, county, and state)

10. Usual Occupation Inspector

11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Blair Jenkins
13. Birthplace

MOTHER
14. Maiden Name Barbara Shank
15. Birthplace Lincoln Co. N.C.

16 (a) Informant Warlick Funeral Home
(b) Address Lincolnton, N. C.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/15/44 (month) (day) (year)

(c) Cemetery or crematory
Location Lincolnton, N. C.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 15 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/14 1944, at 10.20 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNalley M.D.
Medical Examiner.
Date signed 9/13/44

(over)

G20792 [illegible] 42-08822 G20792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4 159

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 4013 Granite Qy. St., 47 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Carroll Bartenieu

(a) Residence: No. 4013 Granite St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Boy	W	Infant

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of Premature

6. DATE OF BIRTH (month, day, year) Sept 13 - 1944

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7 hrs.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Premature

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Baltimore Md

FATHER

13. NAME Wm F. Bertenieu

14. BIRTHPLACE (city or town) (State or country) Md D. Md

MOTHER

15. MAIDEN NAME Elizabeth Klein

16. BIRTHPLACE (city or town) (State or country) Baltimore Md

17. INFORMANT My own Wm F. Klein

(Address) 4013 Granite ave

18. BURIAL, CREMATION, OR REMOVAL

Place UNIVERSITY MEDICAL SCHOOL Date SEP 14 1944 19

19. UNDERTAKER Commissioner of Health

(Address)

20. SEP 15 1944 Huntington Williams

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 9/13/44, 19

22. I HEREBY CERTIFY, That I attended deceased from Sept 13 19 44 to Sept 13 1944.

I last saw him alive on Sept 13 1944 Death is said to have occurred on the date stated above, at 7 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Prematurity	Birth
Other contributory causes of importance:	—

Name of operation — Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Edward Zimmerman M. D.

(Address) 2147 1826 Harford Rd

No. 1—WHITE PRINTING, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G20793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48 B

G20793 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. See correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 Homewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Estelle A McCoy

3 (b) If veteran, name war: —
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Robert
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1892

8. AGE: Years 52 | Months 0 | Days 21 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housemaid
11. Industry or business

FATHER 12. Name	Wilhelmina H Keller
FATHER 13. Birthplace	Washington D C
MOTHER 14. Maiden Name	Amanda Steinlein
MOTHER 15. Birthplace	Washington D C

16 (a) Informant Robert McCoy
(b) Address 1711 E Fed[illegible] St

17. Burial (Burial, cremation, or removal) (b) Date thereof 9/16/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Baltimore Md

18 (a) Funeral director Williams Funeral Home
(b) Address 1217 E Fort Ave

19 (a) SEP 15 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 6 19[illegible], to Sept 12 19 44 and that I last saw [illegible] alive on Sept 12 19 44

Immediate cause of death Carcinoma of uterus

Duration

Due to

Due to

Other Conditions Carcinoma of stomach
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Hornstein M. D.
Address 733 Argyle St Date signed 9/14/44

VS 150

G20794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20794 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 Bolton st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 Bolton st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Nelms

3 (b) If veteran, name war: W
3 (c) Social Security Account No. [illegible]

4. Sex: Female
5. Color or race: White
6 (a) ~~Single, married~~ widowed, or divorced: Widowed
6 (b) Name of husband ~~or wife~~: Lon H. Nelms
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 16th 1944

8. AGE: Years: 74 | Months: 0 | Days: 28 | If less than one day: hr. 18 min. 10

9. Birthplace: Newton Co. Ga.
(Town, county, and state)

10. Usual Occupation: At home
11. Industry or business: Sick

FATHER
12. Name: Doc Whitker
13. Birthplace: Rockdale Co. Ga.

MOTHER
14. Maiden Name: Kate (Unknown)
15. Birthplace: Rockdale Co. Ga.

16 (a) Informant: Claude Gunter Jr
(b) Address: 1613 Bolton st (Elon

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/44 (month) (day) (year)
(c) Cemetery or crematory: St. Mary's
Location: Hampden - Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 E. Paul St.

19 (a) Filed 1944 (b) Registrar: Williams, Washington Williams, M.D.

vs

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14th 1944, at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31- 1944 to Sept 14 1944, and that I last saw h[illegible] alive on [illegible] 13 1944.

Immediate cause of death: Myocardial insuff. — Duration: 1 Day
Due to: Chr. Myocarditis — 2 yrs
Due to:
Other Conditions: Not Known
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: Chas. J. Keller M. D.
Address 2220 W. Monument Date signed 9/19/44

M. H. R. 1288-9

G20795 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G20795

CERTIFICATE OF DEATH 13 51 D

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 2713 Strathmore ave St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME John Edw. Mac Cubbin, Sr.

(a) Residence: No. 2713 Strathmore ave St., Ward. S. S. 215-09-7525

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Eleanore M. Mac Cubbin

6. DATE OF BIRTH (month, day, year) May 30 1881

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	4	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Surveyor.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto.

FATHER

13. NAME Henry M. Mac Cubbin

14. BIRTHPLACE (city or town) (State or country) Md.

MOTHER

15. MAIDEN NAME Catharine Weigert

16. BIRTHPLACE (city or town) (State or country) Md.

17. INFORMANT (Address) John E. Mac Cubbin Jr. 2713 Strathmore Ave

18. BURIAL, CREMATION, OR REMOVAL Place London Park Date 9-16 19 44

19. UNDERTAKER (Address) L. J. Burgh 3 Chas Hayford Rd.

Filed SEP 15 1944 19 Registrar. Lee Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 14 — 1944

22. I HEREBY CERTIFY, That I attended deceased from Feb 13 — 1943. to Sept 14 — 1944

I last saw h. alive on Sept 9 — 1944. Death is said to have occurred on the date stated above, at 9 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of prostate	Unk.

Other contributory causes of importance:

Name of operation Prostatectomy Date of Feb 1944

What test confirmed diagnosis? Path. Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) Chas J. Keller M. D.

(Address) 222 W. Monument St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G20796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20796

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED?
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Market St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Holley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Elizabeth M. Holley

6 (c) If alive, give age 86 years

7. Birth date of deceased (mo., day, yr.) March 28, 1857

8. AGE: Years 87 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county, and state)

10. Usual Occupation Retired Bandsman

11. Industry or business U. S. Naval Academy

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Andreas Z. Holley
(b) Address Market St., Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1944 (month) (day) (year)
(c) Cemetery or crematory National Cemetery
Location Annapolis, Md.

18 (a) Funeral director E. W. Paumier
(b) Address 1003 W. Baltimore St.

19 (a) 1944 Filed by registrar (b) Huntington Williams, M.D. Registrar

VB 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 9 1944, to Sept 14 1944, and that I last saw him alive on Sept 14 1944

Immediate cause of death	Duration
Chronic Myocarditis	Indef.
Due to	
Due to	
Other Conditions Arterio Sclerosis and Chronic Myocarditis (Include pregnancy within 3 months of death)	Indef.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Richardson M.D.
Address 112 W. 25th St. Date signed 9/15/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

MARGIN RESERVED FOR BINDING

G20797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a

Registered No. G20797

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1105 N. Monroe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa A. Stengen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color of race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15 1867

8. AGE: Years	Months	Days	If less than one day
75	8	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Nicholas Stengen
13. Birthplace Baltimore

MOTHER
14. Maiden Name Barbara Kolb
15. Birthplace Baltimore

16 (a) Informant Mrs Helen Wade
(b) Address 1105 N. Monroe St

17 (a) Burial Holy Redeemer (Burial, cremation, or removal) (b) Date thereof 9-16-44 (month) (day) (year)
(c) Cemetery or Crematory Holy Redeemer Cemetery
Location Beltsville Md

18 (a) Funeral director Randell L. Humphreys
(b) Address 1344 Broadway

19 (a) SEP 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12th 1944, at 9.45 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 4 1944 to Sept. 13 1944 and that I last saw h[illegible] alive on Sept. 12 1944

Immediate cause of death CEREBRAL HEMORRHAGE — Duration 9 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harry J. D. Rosenthal M. D.
Address 1907 Eutaw Place Date signed Sept 14 1944

G20798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 823a

G20798 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Presbury St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Presbury
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Dorsey

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 12, 1888
8. AGE: Years 56 | Months 55 | Days 3 | If less than one day hr. 1 min.
9. Birthplace Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant James Jones
(b) Address 1722 Presbury St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-16-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George H. Wilson
(b) Address 1303 Presstman St

19 SEP 16 1944 (Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1944, at P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1944 to 9-13 1944 and that I last saw her alive on 9-13 1944.

Immediate cause of death Cerebral Hemorrhage — Duration
Due to Vascular hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. R. Campbell M. D.
Address 718 Dolphin St. Date signed 9-15-44

VS 150

Huntington Williams M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G20799 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: Univ. Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 da
(e) Length of stay in Baltimore (yrs., mos., or days) 11 da.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1449 Wood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Bl.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26, 1944

8. AGE: Years	Months	Days	If less than one day
		17	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Roland Johnson

13. Birthplace

MOTHER 14. Maiden Name Sarah

15. Birthplace

16 (a) Informant No next of kin

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 16 1944 Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-6 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 1944, to 9-6 1944, and that I last saw her alive on 9-6 1944.

Immediate cause of death	Duration
Dehydration + toxicity	
Due to Diarrhea of newborn	4 da.
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Lange M. D.

Address Infirmary Hosp. Date signed 9-13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2158

G20800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G20800 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: President Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 567 Mosher St. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No) If yes, name country

3 (a) FULL NAME Loretta Cora White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-12-44

8. AGE: Years | Months | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Leslie White
13. Birthplace Greenburg Pa.

MOTHER
14. Maiden Name Thelma Olivia Barnes
15. Birthplace Baltimore Md.

16 (a) Informant Thelma White
(b) Address 567 Mosher St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 16 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-10-1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-1944 to 9-10-1944, and that I last saw h[illegible] alive on 9-10-1944.

Immediate cause of death Bronchopneumonia — Duration 9 Days

Due to

Due to

Other Conditions prematurity — 7 hrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: —

of autopsy: bronchopneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Ward, M. D.
Address 516 Mosher St. Date signed 9.11.44

2150

G20801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20801 Registered No.

MARGIN RESERVED FOR BINDING. The Law requires that every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item must be answered or "Unknown" or "None" inserted where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2328 E Fleming St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl McLaurea

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1944

8. AGE: Years	Months	Days	If less than one day
		5	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Gloria McLaurea
15. Birthplace New York

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 16 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 28, 1944 to Sept 3 1944.
and that I last saw h[illegible] alive on Sept 3, 1944.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hilbun E. Wells M.D.
Address Univ. Hosp. Date signed 9/14/44

VS 150 2151

G20802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G20802

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene sts
(c) Hospital or institution:
University Hospital 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 162 W. West st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Avery

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	Infant

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-44

8. AGE: Years | Months | Days | If less than one day 3 hr. 30 min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry James Spears
13. Birthplace Manningville S.C.

MOTHER 14. Maiden Name Armanda Carie Avery
15. Birthplace Clarey, Sc.

16 (a) Informant Armanda Avery
(b) Address 162 W. West st.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory UNIVERSITY MEDICAL SCHOOL SEP 15 1944
Location

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 16 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1944 to 9-9 1944, and that I last saw her alive on 9-9 1944

Immediate cause of death Prematurity
birth wt 2lb 4oz

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Lynn M. D.
Address University hospital Date signed 9-9-44

f 2152

G20803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20803 / 119a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Green St
(c) Hospital or institution: University Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da
(e) Length of stay in Baltimore (yrs., mos., or days) 4 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 McCulloh St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Weaver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Bl. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/28/44

8. AGE: Years | Months | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Louise Weaver
15. Birthplace Columbus Ohio

16 (a) Informant Senior Weaver
(b) Address 1618 McCulloh St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 16 1944 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1 1944, at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-29 1944 to 9-1 1944, and that I last saw h[illegible] alive on 9-1 1944

Immediate cause of death	Duration
Dehydration + Toxicity	
Due to Diarrhea of newborn	4 da.
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Lange M. D.
Address Univ. Hosp. Date signed 9-1

VS 250

2153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20804

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 160a

Registered No. G20804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 6 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 308-20½ St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Gloria Teresa Matthews (Richardson) Mathews
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: negro | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-30-44

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Lincoln Rogers Matthews
13. Birthplace Accomack County, Va.

MOTHER
14. Maiden Name Irene Miles
15. Birthplace Accomack county Va.

16 (a) Informant Irene Richardson
(b) Address 308-20½ St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 3 1944 at 4:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1944 to 9-3 1944, and that I last saw h.a.r. alive on 9-3 1944

Immediate cause of death — Duration

Due to Intra cranial Hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carson L. Johnson M. D.
Address Provident Hospital Date signed 9/11/44

VS 150

2154

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G20805

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1430 McCulloh St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Davis

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	negro	newborn

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-30-44

8. AGE: Years	Months	Days	If less than one day
			8 hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alex Farrier
13. Birthplace Va.

MOTHER
14. Maiden Name Lucinda Davis
15. Birthplace South Hill Va.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 16 1944 (Date rec'd by registrar) (Signature of Registrar) Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-30-1944, at 8 40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30-1944 to 8 40 8-30-1944, and that I last saw him alive on 8-30-1944.

Immediate cause of death	Duration
Atelectasis	1 hr.
Due to Prematurity	1 hr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature N. Louise Torry, M.D.
Address 1430 Division St. Date signed 8/31/44

2155

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND LAW RESERVED FOR READING

G20806

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20806 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 14 Division Street
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hr. 10 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 8 1/2 hours

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-1-44

8. AGE: Years — | Months — | Days — | If less than one day 8 hr. 30 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Rufus Bell
13. Birthplace Cape Charles, Va.

MOTHER
14. Maiden Name Lucy Ella Coles
15. Birthplace Morrisville, Va.

16 (a) Informant Lucy Bell
(b) Address 1213 N Eden Street

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 16 1944 (Date rec'd by registrar) (Signature) Wm. Tilden Williams, M.D. Registrar

VS 159

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-1- 1944, at 5 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 ; and that I last saw her alive on 9-1- 1944

Immediate cause of death: Premature Birth — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. LeRoy Perry M. D.
Address 420 E. Chase Date signed 10-4-44

2156

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20807 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore Middle River
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 38 Chandelle Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Lane, Baby Boy

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1944

8. AGE: Years	Months	Days	If less than one day
		1 day	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER

12. Name Lane, Robert

13. Birthplace South Carolina

14. Maiden Name Jones, Estelle

15. Birthplace South Carolina

16 (a) Informant —

(b) Address —

17 (a) —
(Burial, cremation, or removal) (b) Date thereof — (month) (day) (year)

(c) Cemetery or crematory —
Location UNIVERSITY MEDICAL SCHOOL SEP 15 1944

18 (a) Funeral director Commissioner of Health

(b) Address —

19 SEP 16 1944 (Date rec'd by registrar) (Signature) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 12, 1944 at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from — 19 — to — 19 —, and that I last saw h— alive on — 19 —.

Immediate cause of death	Duration
Asphyxia Respiratory Failure	
Due to Prematurity	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Charles Stanes Hatch, M. D.

Address — Sept. 15 44 Date signed

12157 Church Home Hospital

G20808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

2G20808 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 648 W. Saratoga St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 648 W. Saratoga St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Vincenza Citrano

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Antinio

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 26 1873

8. AGE: Years	Months	Days	If less than one day
71	7	18	hr. min.

9. Birthplace: Italy (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Antonio Maranto
13. Birthplace: Italy

MOTHER
14. Maiden Name: Angelina Barranco
15. Birthplace: Italy

16 (a) Informant: Joesph Citrano Son
(b) Address: 648 W. Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEPT. 18 44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd & Moravia

18 (a) Funeral director: Frank Leely Noze
(b) Address: Morley Ave

SEP 16 1944

19 (a) (Date rec'd by registrar) (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep. 14 1944, at 3.50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sep 1, 1944, to Sep. 13, 1944, and that I last saw her alive on Sep. 12 1944.

Immediate cause of death	Duration
Myocarditis (Chronic)	2
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Eugene L. Passaguo M. D.
Address 514 Drury Lane Date signed 9/15/44

Hunter Williams M.D.

C20809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

I C20809 Registered No. 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 244 Albemarle St.
(c) Hospital or institution:
RES.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 244 Albemarle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sabatino Collevecchio

3 (b) If veteran, name war	3 (c) Social Security Account No.

4 Sex	5 Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Faustina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 3 1869

8. AGE: Years	Months	Days	If less than one day
75	4	12	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Josephatti
13. Birthplace Italy

MOTHER
14. Maiden Name Giglia Zamponi
15. Birthplace Italy

16 (a) Informant Wife
(b) Address 244 Albemarle

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd & Moravia Ave

18 (a) Funeral director Frank Della Vale
(b) Address 52 N. Morley St.

19 (a) (Date received by registrar) SEP 16 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5, 1944 to Sept. 15, 1944 and that I last saw him alive on Sept. 15, 1944

Immediate cause of death — Duration

Cancerous Thrombosis — 10 days
Due to Arterio Sclerosis — 2

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene L. Cavagnaro M. D.
Address 514 Drury Lane Date signed 9/15/1944

Huntington Williams, M.D.

Ex Transcript of Death

1123 G20810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G20810 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARK "RESERVED FOR RECORDING"

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2913 Keswick Road.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2913 Keswick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Goldie Mentzell.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John T. Mentzell
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1883

8. AGE: Years 60 | Months 11 | Days 4 | If less than one day hr. min.

9. Birthplace Maryland.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Laumann.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Cecilia Tracy.
15. Birthplace Maryland.

16 (a) Informant John T. Mentzell
(b) Address 2913 Keswick Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Wash. Blvd & [illegible]

18 (a) Funeral director Edmund F. Donovan
(b) Address 3615 N Charles St Ave.

19 (a) (Date received by Registrar) SEP 16 1944 (b) Washington Hill Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1944 at 10 55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 5 1944 to Sept 14 1944 and that I last saw he alive on 9/14 1944.

Immediate cause of death Myocardial failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature C. T. Frankhauser M. D.
Address 125 at Park St. Date signed

H.D. Franklin

G20811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G20811

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Aisquith St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nick Kost Baouris

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-07-3903

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Zaharoula Baouris
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Turkey (Town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business Bethlehem Fairfield

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant C. Veveteulis
(b) Address 711 S. Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md.

18 (a) Funeral director F. Sharrow & Sons
(b) Address Westminster

19 (a) (Date rec'd) SEP 16 1944 (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1944 at 11 50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1944 to Sept 14 1944 and that I last saw h[illegible] alive on 9-13 1944

Immediate cause of death	Duration
Nephritis	1 yr
Due to	
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Goveton M.D.
Address 101 N Read St. Date signed 9/14/44

G20812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G20812 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1327 W. Fayette St.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1327 W. Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred V. Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Robert Wright
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2, 1901

8. AGE: Years	Months	Days,	If less than one day
43	1	12	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charles Elloff
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah McCluskey
15. Birthplace Md.

16 (a) Informant Son. Edgar Wright
(b) Address 1327 W. Fayette St.

17 (a) Burial (b) Date thereof Sept 16, 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location Baltimore, Md.

18 (a) Funeral director D. J. Conway Co.
(b) Address 21 W. 25 St. #18

19 (a) Registered by registrar SEP 19 1944 Registrar
VS 10g

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14-44, 19..., at 7 ... M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7-44, to 9-14-44, and that I last saw her alive on 9-14-44

Immediate cause of death	Duration
Adams-Stokes attack	
Due to Hypertensive C.V.	
Due to disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy: Confirmed.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Thornton Lee, M. D.
Address Univ. Hosp. Date signed 9-17-44

H. Hunter Williams, M.D.

G20813

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √13a

G20813 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 Warner St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22
(e) Length of stay in Baltimore (yrs., mos., or days) 9yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 Warner St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert Jackson | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 31, 1896

8. AGE: Years 48 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Fredericksburg Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Geo. Crump
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Spotsylvania Co. Va

16 (a) Informant Robt. Jackson
(b) Address 628 Warner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 16 1944 (month) (day) (year)
(c) Cemetery or crematory Fredericksburg, Va.
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1944 at 5.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1944 to Sept 14 1944 and that I last saw her alive on Sept 13 1944

Immediate cause of death: Chr. Cardio-renal Disease — Duration about 1 year

Due to: Unknown

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John W. Gaines
Address 665 W. Barre St. Date signed 9/15/44

Huntington Williams M.E.

G20814

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √94a

G20814 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 4yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2325 N. Calvert (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Argend Armstrong E. Armstrong

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. 234-24-4814

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary Armstrong
6 (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1889

8. AGE: Years	Months	Days	If less than one day
55	11	9	hr. min.

9. Birthplace Cincinatti Tennessee (Town, county, and state)
10. Usual Occupation Book Keeper
11. Industry or business Hotel

FATHER
12. Name Richard Armstrong
13. Birthplace Kentucky

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs Mary Armstrong
(b) Address 2325 N Calvert St

17 (a) Burial (b) Date thereof Sept 18th 44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location 4300 Old Frederick Rd

18 (a) Funeral director John J Lowery & Son
(b) Address 901-03 Hollins St

19 (a) (Date received by local registrar) SEP 16 1944 (b) Huntingtor Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1944, at 4.25 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to via fungi death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh P. McNally M.D.
Medical Examiner.
Date signed 9/15/44

Every item of information should be carefully written. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20815

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1321 N. Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 N. Milton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

FULL NAME Benjamin GEORGE ~~RABB~~ Raab

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 15 1896

8. AGE: Years 48 ~~47~~ | Months 8 | Days – | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Motorman

11. Industry or business

FATHER
12. Name Benjamin Raab
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Zang
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Marie Frazier
(b) Address 3128 Ravenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Rynk.
(b) Address 5-32 Mayfield Rd.

19 (a) SEP 16 1944 (Date rec'd by registrar) (b) Huntington Ave Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 19 44 at 11 50 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ ~~or~~ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 9-16-44

AR 39500 G20816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20816 Registered No. 132

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos- 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Druid Hill Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Fulton-or-Robert Fuller-or- Robert Fields or Robert Fullard

3 (b) If veteran, name war

3 (c) Social Security Account No. 240-30-2442

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15-1905

8. AGE: Years	Months	Days	If less than one day
39	0	29	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation Rug Factory

11. Industry or business

FATHER
12. Name Samuel Fulton-Fuller or Fields(D)
13. Birthplace ?

MOTHER
14. Maiden Name Pauline Mc Fadden (D)
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) Filed SEP 16 1944 (b) Huntington Williams M.R. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 14- 1944 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 4- 18- 1944 to 9- 14- 1944, and that I last saw h. im alive on 9- 14- 1944

Immediate cause of death	Duration
Chronic Pulmonary Tuberculosis	?
Due to	
Due to	
Other Conditions coronary sclerosis (Include pregnancy within 3 months of death)	?

Date of operation
Major findings of operation
of autopsy same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle
Address Balt City Hosp. Date signed M. D. 9/19/44

G20817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. G20817

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 829 S. Conkling St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 829 S. Conkling St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George G. Hofmann

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Helene M. DeDelaprat
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1868

8. AGE: Years	Months	Days	If less than one day
76	1	8	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name George G.
13. Birthplace Germany

MOTHER
14. Maiden Name Katherine Heiser
15. Birthplace Germany

16 (a) Informant Mr. E. Hofmann
(b) Address 829 S. Conkling St.

17 (a) Burial (b) Date thereof 9/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

SEP 16 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1944, at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1944 to Sept 14 1944, and that I last saw h— alive on Sept 14 1944

Immediate cause of death	Duration
Cerebral Coalition Myocardial Arterio-Sclerosis	1944 - 44 1938
Due to Myocardial	9yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. H. Williams M.D.
M. D.
Address 38 W. Saratoga Date signed 9/14/44

A. J. Kleckner

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE RESERVED FOR BINDING

G20818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73

Registered No. G20818

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHN HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2128 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leslie Chamblee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-6-15

8. AGE: Years	Months	Days	If less than one day
29.	7	8	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Chamblee
13. Birthplace Va.

MOTHER
14. Maiden Name Anna Sears
15. Birthplace Va.

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 12 44 (month) (day) (year)
(c) Cemetery or crematory
Location Petersburg Va

18 (a) Funeral director Robt E Wilson
(b) Address 515 McElderry St

19 (a) SEP 17 1944 (b) (Local registrar) SEP 16 1944 Huntington Williamsburg Md.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept 14 1944, at 1.37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1944, to Sept 14 1944, and that I last saw him alive on Sept 14 1944

Immediate cause of death: Hemolytic crisis with circulatory failure — Duration

Due to? Sickle cell anemia

Due to Undiagnosed disease - uterus, anemia, hyperpyrexia,

Other Conditions Malarium, Bacteremia due to organisms not yet identified.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Full report not in

of autopsy: Pulmonary edema, hepatic [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Bringham (Don't write) M. D.

Address J H H Date signed 9-14

G20819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20819 Registered No. 13/a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2938 Guilford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret A. Noppenberger

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Ashland, Balto., Co. Md. (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER 12. Name Abram MaGee
13. Birthplace Ireland

MOTHER 14. Maiden Name Matilida Hughes
15. Birthplace Ireland

16 (a) Informant Miss May Noppenberger
(b) Address 2938 Guilford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/44 (month) (day) (year)
(c) Cemetery or crematory St. Josephs
Location Texas, Maryland

18 (a) Funeral director Mary M. Whitfield
(b) Address 501 East 22nd Street

SEP 17 1944 (Date filed with Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15/44 19 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from January 19 35 to Sept 15 19 44 and that I last saw her alive on Sept 14 19 44

Immediate cause of death: Chr. Myocarditis with decompensation — Duration 10 years
Due to: Chr. Mit. Stenosis — Duration 7
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature William K. Speaght M.D.
Address 106 E. Biddle Date signed 9/16/44

G20820

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G20820 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1808 West Fayette St. 1805 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Frances Hilmer

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-01-7763

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2nd 1903

8. AGE: Years 41 | Months 5 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Frederick A. Hilmer

13. Birthplace Md.

MOTHER 14. Maiden Name Frances V. Ralph

15. Birthplace Md.

16 (a) Informant Frederick A. Hilmer

(b) Address 1808 W. Fayette St

17 (a) Burial (b) Date thereof 9/18/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or Crematory Maryland Memorial
Location Baltimore County Md

18 (a) Funeral director F. B. Wippert's Son

(b) Address 300 Eastern Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 17 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1944, at 2.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 7 1944, to Sept 14 1944, and that I last saw h[illegible] alive on Sept 14 1944

Immediate cause of death — Duration

Respiratory Failure — due to Amalignancy of Lungs

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Grahleman M. D.

Address Redwood & Green Date signed Sept 14, 1944

G20821

BALTIMORE CITY HEALTH DEPARTMENT ✓ G20821

CERTIFICATE OF DEATH 12/a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or Institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 E. Henrietta St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA M. M. BRUNT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife William G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Scherer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M. Muller
15. Birthplace Germany

16 (a) Informant Mr. Clarence H. Scherer
(b) Address 2904 Allendale Rd. 16

17 (a) Burial (b) Date thereof 9/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

(By) (Registrar) Huntington Williams, M.D.

SEP 17 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1944 9.20 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Sept 15 1944
and that I last saw her alive on Sept 14 1944

Immediate cause of death

	Duration
Chronic Myocarditis	14 yrs
Due to	
Due to	
Other Conditions Arteriosclerosis	1 dy
Chronic Nephritis	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature H. C. Ratcliffe M. D.
Address 12 W. 20 St. Date signed Sept 15-44

G20822 ✓ G20822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 W
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3604 Marmon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace D. Gruber

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Warner Gruber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-26-1897

8. AGE: Years	Months	Days	If less than one day
46	10	20	hr. min.

9. Birthplace Bivalve Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Oscar T. Insley
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Efford
15. Birthplace Md

16 (a) Informant Mr. Herman L. Gruber
(b) Address 3604 Marmon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 17 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D.

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16 1944 at 3:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1944 to 9-16 1944 and that I last saw h alive on 9/16 1944

Immediate cause of death Circulatory Collapse — Duration
Due to Intestinal Obstruction
Due to
Other Conditions Pt. Refused operation
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. K. Gray
Address Mercy Hosp. Date signed 9/16/44 D

330 46 G20823

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20823

CERTIFICATE OF DEATH 46D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.J. (b) County
(c) City or town Atlantic City (If outside city or town limits, write RURAL and give town)
(d) Street No. Shore Manor 17 S. Brighton Ave. (If rural, give district)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace E. Tangeary

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 8-11-86

8. AGE: Years 58 | Months 1 | Days 4 | If less than one day hr. min.

9. Birthplace: Van Wert Ohio (Town, county, and state)

10. Usual Occupation: Promotion Mgr. of Guest House

11. Industry or business: Hotel Business

FATHER
12. Name: John Wesley Tangeary
13. Birthplace: Washington Ct. House (Ohio)

MOTHER
14. Maiden Name: Rebecca Taylor
15. Birthplace: Fayette Co., (Ohio)

16 (a) Informant: Records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/16/44 (month) (day) (year)
(c) Cemetery or crematory
Location: Van Wert, Ohio

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

SEP 17 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15-1944, at 11.00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8-24-1944 to 9-15-1944 and that I last saw her alive on 9-15-1944

Immediate cause of death: Coronary Thrombosis & Pulmonary Embolism — Duration: -

Due to:

Due to:

Other Conditions: Ca of Rectum Post op.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: Ca of Rectum

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Wm. G. Reinhardt

Address: Date signed

MARION RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G20824

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

✓ G20824 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital - Balto. Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) N.
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2303 E. Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Rackmales

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-0879

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Late Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 1, 1881

8. AGE: Years	Months	Days	If less than one day
63	8	15	hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business Manager Cigar Store

FATHER
12. Name Hirsh Rackmales
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a) Informant Kit Rackmales
(b) Address 3618 Park Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept, 17, (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cem
Location E Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 N Howard Ave

SEP 17 1944 (Date filed by Registrar) Huntington Williams, M.D. (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1944 at 1:27 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1944 to 9/16 1944, and that I last saw him alive on 9/15 1944.

Immediate cause of death C-R failure — Duration

Due to Cardiac

Due to Carcinoma of colon

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/13 12/43 1944

Major findings of operation: Ca of colon — hydrous fluxus

of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac Lichalin M. D.
Address Sinai Hospital Date signed 9/16/44

MUNIKER G20825

G20825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2323 Callow Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Meinhei

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years 66 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Sefton

11. Industry or business

FATHER
12. Name Jacob
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Sarah
(b) Address 2323 Callow Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 9-17-44

(c) Cemetery or crematory Hebrew Mt. Carmel United Hebrew Cem
Location Rock Spring Rd

18 (a) Funeral director Jack Levine Inc
(b) Address 1431 E. Baltimore St

19 (a) SEP 17 1944 (Date rec'd by registrar) H. Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15 1944, at 11 50 M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 9-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G20826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20826 Registered No. 1314

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1619 McKean ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1619 McKean ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Stulman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Israel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGES: Years	Months	Days	If less than one day
90			hr. min.

9. Birthplace Russia
(City or town, county, and state)
10. Usual Occupation N. W
11. Industry or business

FATHER
12. Name Abraham
13. Birthplace R.

MOTHER
14. Maiden Name Freida
15. Birthplace R.

16 (a) Informant Morris Stulman
(b) Address 1618 McKean Ave

17 (a) Burial (Burial, cremation, or removal)
(b) Date thereof 9-17-44 (month) (day) (year)
(c) Cemetery or crematory Woodmen Circle
Location O'Donnel St.

18 (a) Funeral director Jos Lewis Sr
(b) Address 1734 E. Balto St
(c) Filed 9-17-1944 (Signature of registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1944 at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1944 to 9/16 1944 and that I last saw alive on 9/16 1944

Immediate cause of death: Cardio-Renal-Vascular

	Duration
Due to: Decem	3 yrs.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benj. Spanierman
Address 2158 W. North Ave Date signed 9/16/44

G20827

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G20827

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address (If outside city limits) Monterey Apt

(c) ~~Hospital or institution~~ LINDEN AVE. + WHITELOCK ST

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. Linden Ave. + Whitelock St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Nannie Cohn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry L. Cohn

13. Birthplace Germany

MOTHER 14. Maiden Name Fannie

15. Birthplace Germany

16 (a) Informant Joel Cohn

(b) Address Monterey Apt

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-17-44 (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew

Location Levin Ave

18 (a) Funeral director Jacob Levin Inc

(b) Address 1439 E. Balto. St

19 (a) (Delivered by registrar) (b) Baltimore, Md.

SEP 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16-44 19 .., at 6 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944, to Sept 16 1944, and that I last saw h[illegible] alive on Sept 15 1944.

Immediate cause of death	Duration
Coronary thrombosis	7 days
Due to	
Due to Arteriosclerosis	5 years
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature I. Frederick Lentz M. D.

Address Temple Emden Apt Date signed Sept 16 44

G20828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20828 X 830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days) D.C.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Lutherean Heights (If outside city or town limits, write RURAL and give town)
(d) Street No. 433 Shipley Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME John Elmer White

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No. 015-03-7233

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Viola G. White.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/30/86

8. AGE: Years 57 | Months 9 | Days 15 | If less than one day hr. min.

9. Birthplace Arkansas (Town, county, and state)
10. Usual Occupation Radio Work
11. Industry or business Westinghouse

FATHER
12. Name John N. White
13. Birthplace Unknown

MOTHER
14. Maiden Name Lucy E. Cartwright
15. Birthplace Unknown

16 (a) Informant Mrs Viola G. White
(b) Address 433 Shipley Rd Lutherean Heights

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/17/44 (month) (day) (year)
(c) Cemetery or crematory Waynesville
Location N. C.

18 (a) Funeral director William Cook Inc
Address 1217 St. Paul St.

19 (a) SEP 17 1944 (Date rec'd by registrar) (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1944 at 7 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/13 1944 to 9/15 1944 and that I last saw h[illegible] alive on 9/15 1944.

Immediate cause of death	Duration
Card. Failure	
Due to Cerebro-Vascular accident.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify which place) While at work?
(e) Means of injury

23. Signature R. M. A. Crosby
Address Mercy Hospital Date signed 9/15

VS 150

G20829 G20829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5815 Ethelbert Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5815 Ethelbert ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sadie M. Xander

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband William F. Xander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1886

8. AGE: Years 58 | Months 0 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name William Jennings
13. Birthplace Va.

MOTHER
14. Maiden Name (Not Known) Lee
15. Birthplace Va

16 (a) Informant William F. Xander
(b) Address 5810 Ethelbert Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/44 (month) (day) (year)
(c) Cemetery or crematory David Ridge
Location Pikesville Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 W. Lexington St

19 (a) 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14th 1944, at 5:20 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 5 1944, to Sept 14 1944, and that I last saw h[er] alive on Sept 14th 1944

Immediate cause of death Coronary Thrombosis — Duration Lev. Mos:

Due to Arteriosclerosis

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Blum, M.D.

Address 3431 Park Heights Ave Baltimore, 15 Date signed 9/12/44 M. D.

VS 150

G20830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G20830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1.0. 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3304 Hudson Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Hubbe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 28, 1882

8. AGE: Years	Months	Days	If less than one day
62	2	17	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Henry Hubbe
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine Luther
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Minnie Weigrand
(b) Address 3304 Hudson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 1944 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location Balto. Md.

18 (a) Funeral director Williams Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) SEP 17 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15, 1944, at 5 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary Arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D. Medical Examiner.
Date signed September 16, 1944

G20831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

G20831 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 E. Univ. Pkwy.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Wm. Reed Seal

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1885

8. AGE: Years 59 | Months 4 | Days 1918 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation State Bank Examiner

11. Industry or business

FATHER
12. Name Mr. Thomas N. Seal
13. Birthplace Maryland

MOTHER
14. Maiden Name Johanna Roth Seal
15. Birthplace Maryland

16 (a) Informant Jos. F. Farbe
(b) Address 3712 Nortonia Rd

17 (a) Entombment (b) Date thereof 9/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received 9 17 1944 (b) Registrar Thurston Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-16 1944, at 7 04 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1944 to 9-16 1944 and that I last saw h.im alive on 9-16 1944

Immediate cause of death: Cardio-Resp. Failure — Duration
Due to: Uremia
Due to: Hypertensive Cardio-Renal Disease
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas L. Chaffee M. D.
Address Union Memorial Hospital Date signed 9-16-44

G20832 G20832

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 211 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto, Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 211 Garrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gillard Vincent McFredericks
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) ~~Single, married,~~ widowed, or ~~divorced~~ Widower
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 19, 1877
8. AGE: Years 67 Months 7 Days 29 If less than one day hr. min.
9. Birthplace Balto. Md (Town, county, and state)
10. Usual Occupation Jr Lawyer
11. Industry or business
FATHER 12. Name Thomas Vincent
13. Birthplace England
MOTHER 14. Maiden Name Ardina Hughes
15. Birthplace Md
16 (a) Informant Mrs Grace Ogletree
(b) Address 211 Garrison Blvd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 18/44 (month) (day) (year)
(c) Cemetery or crematory Westerns
Location Edmondson Ave
18 (a) Funeral director John J. Truth Sullivan Sons
(b) Address 1901 Eutaw Pl.
19 (a) Huntington Williams Md
(Date rec'd by registrar) SEP 17 1944
VS 1B

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1944 at 2.30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Sept 1944, and that I last saw her alive on Sept 11 1944.
Immediate cause of death Lymphosarcoma — Duration 6 Months
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Biopsy - May 1944
Major findings of operations: Biopsy of gland showed Lymphatic Sarcoma
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature L. Harrell Pierce M. D.
Address Med. arts. Bldg Date signed 9-17-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 16/a

G20833 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So. Balto. Gen. Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 3

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE - Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3925 Baltimore Rd. 29
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl NOE (No 2)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/44

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name JAMES N. NOE
13. Birthplace D.C.

MOTHER
14. Maiden Name Ruth Weber
15. Birthplace D.C.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-18-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Woodlawn, Md.

18 (a) Funeral director Francis Loeffler
(b) Address 3821 W. Lafayette Ave. Woodlawn
(b) Huntington Williams

SEP 18 1944

SEP 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17th 1944, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14-1944 to 9-17-1944, and that I last saw her alive on 9-17-1944.

Immediate cause of death: ATELECTASIS OF Rt LUNG.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Lukats, M.D.
Address 213 Light St. Date signed 9/17/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20834
AB-70114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G20834
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7mos 16 days
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2019 E. Preston St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael R. Jones

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 22-1905

8. AGE: Years	Months	Days	If less than one day
39	0	16	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Evan Jones
13. Birthplace South Wales-England

MOTHER
14. Maiden Name Minnie Sullivan
15. Birthplace South Wales-England

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (b) Date thereof 9/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Edmondson Ave & Catonsville Rd

18 (a) Funeral director Geo. [illegible]
(b) Address 3[illegible] Eutaw St.

19 SEP 18 1944 (b)
(Date received by local registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 8------19 44, at 8.50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1--12----19 43, to 9---8 1944, and that I last saw h im alive on 9---8-- 19 44.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Pilloffi M. D.
Address Balt City Hosp Date signed 9-9-44

G20835 P. Alexis P. Davis ✓ G20835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. ~~(yrs., mos., or days)~~ 2
(e) Length of stay in Baltimore (yrs., ~~mos., or days~~) 38

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Cathedral Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alexis P. Davis

3 (b) If veteran, name war Ex Spanish American | 3 (c) Social Security Account No. 219-20-7094

4. Sex M | 5. Color or race W | 6 (a) ~~Single, married,~~ (widowed) or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1859

8. AGE: Years 86 | Months 7 | Days 23 | If less than one day hr. min.

9. Birthplace Hudson Falls New York (Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER 12. Name Davis, Mr. Hathan B

13. Birthplace Cohoes N.Y.

MOTHER 14. Maiden Name Froal, Mrs Charlotte

15. Birthplace Utica, New York

16 (a) Informant Hosp. Record

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 1944 (month, day) (year)

(c) Cemetery ~~or crematory~~ Druid Ridge

Location Pikesville Md

18 (a) Funeral director Henry W. Kuhn's Sons Co

(b) Address McCulloh & Orchard Sts

19 (a) Date received by registrar SEP 18 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944, to Sept 16 1944, and that I last saw h. ~~li~~ alive on Sept 16 1944.

Immediate cause of death Carcinomatosis — Duration

Due to

Due to

Other Conditions Pulmonary edema — years

(Include pregnancy within 3 months of death)

Date of operation

Major findings ~~of operation~~

of autopsy: Carcinomatosis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marion M. Nachlas, M. D.

Address Church Home Hosp. Date signed 9/18/44

G20836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a

G20836

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 N. Mechanic St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Sarah Jones

3 (b) If veteran, name war: --

3 (c) Social Security Account No.: --

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1882

8. AGE: Years	Months	Days	If less than one day
62	3	25	hr. min.

9. Birthplace England
(Town, county, and state)

10. Usual Occupation --

11. Industry or business

FATHER
12. Name Michel Quinn
13. Birthplace England

MOTHER
14. Maiden Name Nellie Moran
15. Birthplace England

16 (a) Informant Louis Stein, Inc.
(b) Address Cumberland, Md.

17 (a) Removal (b) Date thereof 9/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Patrick's Cem.
Location Cumberland, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) (b) Huntington Williams, M.D.
Registrar

SEP 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1944 to 19; and that I last saw her alive on 9-17 1944

Immediate cause of death	Duration
Respiratory failure + Cardiac failure	
Due to cerebral Hemorrhage	5 hrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Range M. D.
Address Minor Bldg. Date signed 9-17-44

G20837 BALTIMORE CITY HEALTH DEPARTMENT G20837 Registered No.

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2216 W. North Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie J. Bunting (Carrie Amelia Bunting)

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Millard R. Bunting
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1881

8. AGE: Years 54 | Months 3 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John R. Korb
13. Birthplace Md.

MOTHER
14. Maiden Name Bertha Schneider
15. Birthplace Germany

16 (a) Informant Mr. Millard R. Bunting
(b) Address 2216 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 Date received SEP 18 1944 Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1944 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1944 to 9/16 1944, and that I last saw h.e alive on 9/15 1944

Immediate cause of death: Cerebro-vascular accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Meyer M. D.
Address 1 W. Mt. Vernon Pl. Date signed 9/17/44

G20838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G20838 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2402 Talbot Rd.
(c) Hospital or institution:
1509
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 2402 Talbot Rd.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES FRED O'CONNOR, SR.

3 (b) If veteran, name war: --

3 (c) Social Security Account No. 212-05-9209

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose T. O'Connor

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 13, 1875

8. AGE: Years: 69 | Months: 2 | Days: 2 | If less than one day: hr. min.

9. Birthplace: D. C. (Town, county, and state)

10. Usual Occupation: Vice-Pres.

11. Industry or business: Consolidated Eng. Co.

FATHER
12. Name: Charles O'Connor
13. Birthplace: D. C.

MOTHER
14. Maiden Name: Anna Cogswell
15. Birthplace: D. C.

16 (a) Informant: Miss Dora Gertrude O'Connor
(b) Address: 2402 Talbot Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 18 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1944, at 10 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 8 1944, to Sept. 15 1944, and that I last saw h... alive on ... 19...

Immediate cause of death: Bronchs - pneumonia

Due to: (1) Arterio - Sclerosis.

Due to: (2) Hypertension.

Due to: (3) Cardiac enlargement

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles S Nesbitt. M. D.

Address 1730 Linden Ave Date signed Sept. 18/44

Huntington Williams, M.D.

G20839 BALTIMORE CITY HEALTH DEPARTMENT G20839

CERTIFICATE OF DEATH 13a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 219 N. Patterson Pk. Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 219 N. Patterson Pk. Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH REESER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1883

8. AGE: Years 60 | Months 9 | Days 10 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nicholas Reiss
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Keck
15. Birthplace Baltimore, Md

16 (a) Informant Miss Minnie Keck
(b) Address 1220 N. Patterson Pk. Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 18-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) SEP 18 1944 (Date received by registrar) (b) Huntington Williams, Md. Signature

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1944, at 6 AM M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 7 1941 to Sept. 15 1944, and that I last saw the alive on Sept. 2 1944.

Immediate cause of death: Coronary Occlusion — Duration 18 mos

Due to Hypertensive Cardio Vascular Renal Disease — 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Israel Rosen M.D. M. D.
Address 2413 E. Monument St Date signed 9/17/44

G20840

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G20840 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave
(c) Hospital or institution: Church Home & Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 62
(e) Length of stay in Baltimore (yrs., mos., or days) Life 55yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2205 Cecil Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELSIE MARGARET WEBB

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: 214-[illegible]-8308

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: George W. Webb
6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.) Jan. 30 1889

8. AGE: Years 55 | Months 7 | Days 18 | If less than one day: hr. min.

9. Birthplace Balto, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H Mylat
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Ida Thompson
15. Birthplace Balto. Md.

16 (a) Informant Mr. George W. Webb
(b) Address 2205 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 20-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) (Date rec'd by Registrar) SEP 18 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944 at 7 40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 1944 to Sept 16 1944 and that I last saw h.e.r. alive on Sept 16 1944.

Immediate cause of death	Duration
Hydro-pneumothorax	
Due to Metastases from Ca of Cervix	
Due to	
Other Conditions (Include pregnancy within three months of death)	

Date of operation Hysterectomy Sept 6 1944
Major findings of operation: Carcinoma Cells on Spun-down material
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature C S Dodge M. D.
Address Church Home & Hosp Date signed Sept 16 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20844
32895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

Registered No. G20841

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Schneider

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Anna

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 2-25-90

8. AGE: Years	Months	Days	If less than one day
54	6	20	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Brick Layer

11. Industry or business

FATHER 12. Name Frederick Schneider

13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth Goth

15. Birthplace Germany

16 (a) Informant Parents

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof SEP 18 1944 (month) (day) (year)

(c) Cemetery or crematory Glen Haven Memorial

Location Rockville Highway

18 (a) Funeral director John A. Madden

(b) Address 3000 E. Balto. St.

19 (a) Date received SEP 18 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15-1944, at 10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6- 1944 to 9-15- 1944 and that I last saw him alive on 9-15- 1944

Immediate cause of death	Duration
Increased intracranial pressure due to metastasis to lobe of brain from primary lung carcinoma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-8-44

Major findings of operation: Brain CA Lung, RU + RML

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Longmire Jr. M.D.

Address Johns Hopkins Hosp. Date signed 9/15/44

G20842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G20842

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 W 28th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 W. 28th St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Matthew Cook

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-03-0608

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1882

8. AGE: Years 62 | Months 7 | Days 6 | If less than one day hr. min.

9. Birthplace Gloucester Co. Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Lancaster Cobbs

13. Birthplace Gloucester Co. Va

MOTHER 14. Maiden Name Agnes Appleton

15. Birthplace Gloucester Co. Va.

16 (a) Informant Matilda Cook

(b) Address 320 W. 28th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18, 1944 (month) (day) (year)

(c) Cemetery or crematory Church Cem. Location Gloucester Co. Va

18 (a) Funeral director Wm. Geo. H. Holland

(b) Address 1631 Druid Hill Ave.

19 (a) Filed SEP 18 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15, 1944, at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Sept 15 1944. and that I last saw h[illegible] alive on Sept 15, 1944.

Immediate cause of death: Hypertensive Cardiovascular Disease — Duration 2 yrs.

Due to:

Due to:

Other Conditions: Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M Cook Obrien

Address 312 E 23rd St Date signed 9-18-44

G20843 ✓ G20843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123W. Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Volkman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1888

8. AGE: Years	Months	Days	If less than one day
56	7	23	hr. min.

9. Birthplace Balto. Md (Town, county and state)
10. Usual Occupation Retired Fireman
11. Industry or business Balto. City

FATHER
12. Name John Volkman
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Seebauer
15. Birthplace Germany

16 (a) Informant George P. Volkman
(b) Address 3138 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9.18.44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Wittke
(b) Address 4101 Edmondson Ave

19 (a) Huntington Williams M.D. (Registrar)

SEP 15 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1944 at 9:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26 1944 to Sept. 14 1944 and that I last saw him alive on Sept. 12 1944

Immediate cause of death	Duration
Lymphosarcoma with metastasis to liver and spleen.	
Due to	
Due to	
Other Conditions Terminal pneumonia	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul G. Lukato
Address 1212 Light St. Date signed 9/14/44 M.D.

G20844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

G20844 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 516 Poplar Grove St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Ward (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha E. Trusheim

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	widow

6 (b) Name of husband or wife Gale Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10. 1873

8. AGE: Years	Months	Days	If less than one day
70	10	5	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

FATHER
12. Name James Young
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name —
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Milton H. Webb
(b) Address 516 Poplar Grove

17 (a) Burial (b) Date thereof 9.18.44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Edmondson Ave.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson ave.

19 (a) (b)
(Undertaker to report) (Signature of local registrar)

SEP 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15- 19 44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-15 19 44 to 9-15 19 44 and that I last saw h[illegible] alive on 9-14 19 44

Immediate cause of death Bronchopneumonia (Hypostatic)

Duration 4 days

Due to Bedridden with arthritis ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation —

of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Morris B. Schwartz M. D.
Address 57 S. Fulton Ave Date signed 9-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20845 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 528 Nottingham Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 528 Nottingham Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES M. MOLLOY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1855

8. AGE: Years 89 | Months 1 | Days 6 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas Molloy
13. Birthplace Ireland

MOTHER
14. Maiden Name Anne Cosgrove
15. Birthplace Ireland

16 (a) Informant Mr. Francis X. Molloy
(b) Address 3428 St. Ambrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert street

19 (a) (Date received) SEP 18 1944 (b) Registrar Huntington Williams Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 16 1944, at 2.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940, to Sept. 1944, and that I last saw her alive on Sept. 1944.

Immediate cause of death	Duration
Hypertensive cardiovascular disease due to essential hyper-	Unknown.
Due to tension.	
Due to	
Other Conditions Only those incident to advanced age. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. F. Boyle Jr. M. D.
11 E. Chase St. Date signed 9.18.44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20846

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1220

G20846 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Gen'l Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Patapsco
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Anderson Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-1276

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Emelia Anderson
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Dec 16 1881

8. AGE: Years	Months	Days	If less than one day
62	8	28	____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Upholstery & Mattress

FATHER
12. Name Frank Anderson
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Dougherty
15. Birthplace Baltimore

16 (a) Informant Emelia Anderson
(b) Address 1315 Patapsco St

17 (a) Burial (b) Date thereof Sept 21
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-8 Eastern Ave

19 (a) (Date rec'd) (Registrar's No.) Registrar

VS-151 SEP 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 11:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Embolism

Due to

Other Conditions Healing Hernia plasty right
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 12 1944

G20847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G20847

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1718 N Wolfe St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 N Wolfe
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adolph Wewerka

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie Wewerka
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1864

8. AGE: Years	Months	Days	If less than one day
80	4	12	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Silversmith
11. Industry or business

FATHER
12. Name Anton Wewerka
13. Birthplace Austria

MOTHER
14. Maiden Name Dont Know
15. Birthplace —

16 (a) Informant August Wewerka
(b) Address 3024 Dona Ter

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto Md

18 (a) Funeral director Weld Funeral Home
(b) Address 2008 Orleans St

19 (a) SEP 18 1944 (Date rec'd by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 5 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12- 1944, to 9-16- 1944, and that I last saw him alive on 9-16- 1944.

Immediate cause of death	Duration
Hypostatic Pneumonia	16 days
Due to Cardio renal vascular disease	4 yrs
Due to Generalized Arteriosclerosis	3 "
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Milton C. Levy M. D.
2117 Belair Rd Date signed 9-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR HEADING

G20848

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G20848 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1301 E. Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1301 E. Hanover St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Holmsted

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1891

8. AGE: Years	Months	Days	If less than one day
52	11	1	hr. min.

9. Birthplace Balto Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Holmsted
13. Birthplace Denmark

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Mrs. J. Schneider
(b) Address 130 E. Hanover st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 18/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem
Location Ritchie Highway

18 (a) Funeral director Fred A. Tydue & Son
(b) Address 216 E. Charles St.

19 (a) (Date received by registrar) (b) SEP 18 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15/1944 at 1:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/44 19 to 9/15 1944, and that I last saw h. alive on 9/15 1944.

Immediate cause of death Uremia c Coma — Duration 3 days
Due to Chronic nephritis c albuminuria — 2 wks
Due to — 2 wks
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller
Address 128 E Charles St Date signed 9/16/44 (M.D.)

G20849

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G20849 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1436 Presstman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1436 Presstman St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Bessie Kelly
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4 Sex Fem.
5. Color or race Col.
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-23-24
8. AGE: Years 19 Months 8 Days 23 If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county and state)
10. Usual Occupation Domestic
11. Industry or business
FATHER 12. Name Arthur Kelly
13. Birthplace D.C.
MOTHER 14. Maiden Name Bessie Thornton
15. Birthplace Md.
16 (a) Informant Helen Kelly
(b) Address 1436 Presstman St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location B.A. County Md
18 (a) Funeral director Wallgren & Jackson
(b) Address 916 Penna Ave
19 (a) (Date rec'd by registrar) (b) Registrar

SEP 18 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15- 1944 at 2:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 3-10- 1942 to 9-15- 1944 and that I last saw h-- alive on 9-13- 1944
Immediate cause of death Pulmonary Tuberculosis — Duration 18 Mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George C Page M.D.
Address 1816 N. Monument St Date signed 9-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G20850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 13

Registered No. G20850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mos- 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 410 N. Pearl St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter Ross

3 (b) If veteran, name war —
3 (c) Social Security Account No. 218-10-4956

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10-1914

8. AGE: Years	Months	Days	If less than one day
30	4	6	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Wessley Ross
13. Birthplace Va.

MOTHER
14. Maiden Name Rose Terry
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals-Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 20- 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

19 (a) (Date rec'd by Registrar) SEP 18 1944

Huntingtown Williamsport Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 16- 1944 at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-20 1944 to 9- 16- 1944 and that I last saw h im alive on 9-16 1944.

Immediate cause of death — Duration

Chronic Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Shea Heller M. D.
Bal City Hosp. Date signed 9/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G20851

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 220 Ridgewood Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 220 Ridgewood Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel W. Lippincott

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Helen Lawrence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28, 1861

8. AGE: Years 83 | Months 0 | Days 20 | If less than one day: hr. min.

9. Birthplace Tennessee
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Henry Lippincott
13. Birthplace

MOTHER
14. Maiden Name Susan Woolston
15. Birthplace

16 (a) Informant Mrs. Helen L. Lippincott
(b) Address 220 Ridgewood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 SEP 18 1944 (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 17 1944 and that I last saw h[illegible] alive on Sept 16 1944

Immediate cause of death: Myocardial [illegible] — Duration: 6 Months
Due to: Arteriosclerosis — ?
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify) While at work?
(e) Means of injury: Weatherbee Fort

23. Signature M. D.
Address 20 E. Preston St. Date signed

WEATHERBEE FORT

G20852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 437

G20852 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Colvin St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hannah (Oberld) Osbourne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M.

6 (b) Name of husband or wife Sam Osbourne
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1899

8. AGE: Years	Months	Days	If less than one day
44	10	27	hr. min.

9. Birthplace MD. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace "

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace "

16 (a) Informant MARTHA JOHNSON
(b) Address 405 COLVIN ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/15/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley Ave

19 SEP 18 1944 Huntington Williams M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1944, at 4:10 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Charles J. Gabrial M.D. Medical Examiner.
Date signed 9/17/44

VS 151

G20853 BALTIMORE CITY HEALTH DEPARTMENT X G20853 Registered No.

CERTIFICATE OF DEATH 1370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Elkridge Harford Hunt Club (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry A. Baylis

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Married

6 (b) Name of husband or wife Florence Baylis
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) June 29 1882

8. AGE: Years	Months	Days	If less than one day
62	2	19	hr. min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Statesman
11. Industry or business Elkridge Harford Hunt Club

FATHER
12. Name George Baylis
13. Birthplace England

MOTHER
14. Maiden Name Matilda Dore
15. Birthplace England

16 (a) Informant Mrs. Florence Baylis
(b) Address 25 W. Penna Ave Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20 44 (month) (day) (year)
(c) Cemetery or crematory St James
Location My Ladies Manor, Balto Co. Md

18 (a) Funeral director Martin Schutz
(b) Address Jarrettsville Md

19 (a) (Signature of local registrar) SEP 18 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1944 at 4:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1944, to Sept 17 1944; and that I last saw him alive on Sept 17 1944.

Immediate cause of death	Duration
Cardiac Failure	
Respiratory Collapse	
Due to	
Due to	
Other Conditions Pneumothorax Uremia (Include pregnancy within 3 months of death)	over

Date of operation 9/15/44
Major findings of operation:
Was autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Guthleman M. D.
Address University Hosp. Date signed 9/17/44

Dr. Herbert Foster 2324 St. Paul St. B2949-P123340

BALTIMORE CITY HEALTH DEPARTMENT

G20854 **CERTIFICATE OF DEATH** (47) Registered No. G20854

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2733 Miles Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2733 Miles Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. McCleary

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary E. McCleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th 1883

8. AGE: Years	Months	Days	If less than one day
61	2	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Officer
11. Industry or business Police Dept. City of Balto

FATHER
12. Name George S. McCleary
13. Birthplace Va.

MOTHER
14. Maiden Name Mary E. Purcell
15. Birthplace Ireland

16 (a) Informant Mrs. Mary E. McCleary
(b) Address 2733 Miles Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/9/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director Wilson Funeral Home
(b) Address 2124 St. Paul St.

19 (a) (Date rec'd by registrar) SEP 18 1944 (b) Thurlington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16th 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1940 to Sept 16 1944, and that I last saw h. alive on Sept 16 1944.

Immediate cause of death	Duration
(a) Acute dilatation of Heart	10 minutes
Due to (b) Carcinoma of Pt. Lung	years
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Herbert M. Foster M.D.
Address 2424 St. Paul St Date signed Sept 17-44

A 3744857 G20855

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 27c

Registered No. G20855

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 Wangler Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Hartzell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-11-44

8. AGE: Years	Months	Days	If less than one day
	3	5	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Abram Hartzell
13. Birthplace Pa.

MOTHER
14. Maiden Name Margaret Heissin
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/18/44 (month) (day) (year)
(c) Cemetery or crematory Zion Lutheran
Location Baltimore Belair Rd.

18 (a) Funeral director John D Conely
(b) Address 4218 Eastern Ave Sept 24

19 (a) (Date rec'd by registrar) (b) Registrar

VS SEP 18 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-15-1944 to 9-16 1944 and that I last saw h[illegible] alive on 9-16 1944

Immediate cause of death: gastro-intestinal hemorrhage — Duration: 32. hrs

Due to: Dyspnea

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address Johns Hopkins Hosp Date signed 9-17-44

G20856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G20856

Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3209 Hudson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Miecznikowski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Sevarina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years 59 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Jos.
13. Birthplace Poland

MOTHER
14. Maiden Name
15. Birthplace Poland

16 (a) Informant Sevarina Miecznikowski
(b) Address 3209 Hudson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd

18 (a) Funeral director Wm. S. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 4.25 P M

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gretter M.D.
Medical Examiner.
Date signed Sept 17 1944

G20857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 8 3a

G20857
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joesph

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Yr.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 237 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Peluso or De Luca

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Louis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1890

8. AGE: Years	Months	Days	If less than one day: hr.	min.
54	4	5		

9. Birthplace Italy
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Frank Litranta
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Caruso
15. Birthplace Italy

16 (a) Informant Son
(b) Address 237 Patapsco Ave

17 (a) Burial (b) Date thereof Sept. 19-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Holy Redeemer
Location Dundalk Md.

18 (a) Funeral director Frank Della Vecchia
(b) Address 52 N. Morley St.

19 (a) SEP 18 1944 (b)
(Date received by registrar) Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1944 at 11 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/15 1944 to 9/15 1944 and that I last saw h[illegible] alive on 9/15 1944

Immediate cause of death	Duration
Centro Vascular Acid	
Due to Hypertension	
Due to	
Other Conditions Pulmonary oedema Cardiac failure	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nicholas Jamontis M.D.
Address 44 Dreyer Road Date signed 9/15/44

Nicholas Jamontis

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20858
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use abbreviations. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6426 Reisterstown Rd.
(c) Hospital or institution: Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-7-16
(e) Length of stay in Baltimore (yrs., mos., or days) 26-7-16

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County Philadelphia
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2551 East Norris St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1881

8. AGE: Years	Months	Days	If less than one day
63	8	4	hr. min.

9. Birthplace Philadelphia, Penna.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business

FATHER
12. Name James White
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Detter
15. Birthplace New Jersey

16 (a) Interment Mount Hope Retreat
(b) Address Baltimore-15, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 20, 1944 (month) (day) (year)

(c) Cemetery or crematory Holy Sepulchre
Location Philadelphia, Penna.

18 (a) Funeral director Stewart & Mowen Company
(b) Address (W.F.Wooden-Suc.) 108 W. North Ave.

SEP 18 1944
(Date received by registrar)

Burlington for Williams MR
(Signature of registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1944, at 11:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1934 to Sept. 18 1944, and that I last saw him alive on Sept. 18 1944.

Immediate cause of death	Duration
Cardiac Vascular Collapse	2 days
Due to Cerebral Arterio Sclerosis	
Due to	
Other Conditions Hypertension Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Barney P. Young M.D.

Address 332 N. Charles St. Date signed 9/19/44

G20859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G20859 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 E. 34th St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town) 3
(d) Street No. 817 E. 34th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EDWARD D. COOPER.

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: MALE
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: MARY C. COOPER
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) AUG. 3- 1864
8. AGE: Years 80 | Months 1 | Days 15 | If less than one day hr. min.
9. Birthplace CHAMBERSBURG, PA. (Town, county, and state)
10. Usual Occupation CARPENTER
11. Industry or business

FATHER
12. Name Philip Cooper
13. Birthplace PA.

MOTHER
14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant MRS. ISABELLE C. KAUFMAN
(b) Address 817 E 34St.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)
(c) Cemetery or crematory CEDAR HILL
Location GREENCASTLE PA.

18 (a) Funeral director J. Howard Strong
(b) Address 3207 W. North Ave
19 (a) SEP 18 1944 (b) Registered by (Signature) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944, to Sept 18 1944, and that I last saw him alive on Sept 18 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration: 2 weeks

Due to: Mitral stenosis — Duration: 5 years

Due to: Hypertension — Duration:

Other Conditions: Rectal Hemorrhage — Duration: 2 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. A. Strudler Jr. M. D.
Address 852 Fawn Ave. Date signed Sept 18/44

G20860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G20860

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Reisterstown Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ella A. Peterson
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Milton D. Peterson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec. 21 1869
8. AGE: Years 74 Months 8 Days 28 If less than one day hr. min.
9. Birthplace Battle Creek Iowa. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Nathan Edwards
13. Birthplace Penna
MOTHER 14. Maiden Name Emily Brown
15. Birthplace Penna.
16 (a) Informant Clara Peterson
(b) Address Reisterstown Md
17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept 20 44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore
18 (a) Funeral director J F Elderdice Sons
(b) Address Reisterstown Md
19 (a) SEP 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1944, at 6 55 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/44 19 to 9/18/44 19, and that I last saw her alive on 9/18/44 19
Immediate cause of death Subarachnoid Hemorrhage — Duration
Due to Arteriosclerosis
Due to
Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Julius Gleich M. D.
Address Franklin Square Hospt Date signed 9/19/44

G20861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

G20861

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 525 Sanford Pl.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret M Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Black	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-7-73

8. AGE: Years	Months	Days	If less than one day
71 69			hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Clark
13. Birthplace N. C.

MOTHER
14. Maiden Name Lucy ?
15. Birthplace N. C.

16 (a) Informant Rescuda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Sept 22-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Baltimore Co

18 (a) Funeral director Sam. N. Chase & Son
(b) Address 1516 N. Gilmor St

SEP 19 1944
(Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17- 1944 at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13-1944, to 9-17-1944, and that I last saw her alive on 9-17-1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Pneumococcus meningitis, Diplo. Pneum. Type 4	9 days
Due to	
Other Conditions Pericarditis, Pernicious anemia, Hypertensive C.V. disease, Syphilis, late	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Gorson

Address 1 Hopkins Date signed 9-17-44

G20862 KAPLAN ✓ BALTIMORE CITY HEALTH DEPARTMENT G20862

CERTIFICATE OF DEATH 52 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Home for Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Sinai Hqrd for the Aged (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Kaplan

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 6, 1857

8. AGE: Years 87 | Months 2 | Days 10 | If less than one day hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Retired Insurance Salesman

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: "
15. Birthplace: "

16 (a) Informant: Sinai Home for Aged
(b) Address: E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) SEP 19 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1944 at 11:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944 to Sept. 16 1944 and that I last saw him alive on Sept. 16 1944.

	Duration
Immediate cause of death: Cardio-respiratory Failure	
Due to: Bronchopneumonia	
Due to: Cachexia	
Other Conditions: Carcinoma of Bladder; Pulmonary Abscess (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operations	
of autopsy: Carcinoma of Bladder; Bronchopneumonia	

PHYSICIAN

Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Alfred H. Dann M. D.
Address Sinai Hosp, Balto. Date signed 9/17/44

G20863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G20863

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Light St.
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Pasadena - Rural (If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane Elizabeth Hunsaker Return #2

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-44

8. AGE: Years 0 | Months 0 | Days 0 | If less than one day 2 hr. 4 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name Edd W Hunsaker
13. Birthplace West Virginia

MOTHER
14. Maiden Name Estella Rhodes
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Edd Hunsaker
(b) Address Pasadena Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 18 1944 (Date rec'd by registrar) (Signature) Hunter Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1944 at 4:17 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1944 to 9-13 1944 and that I last saw h er alive on 9-13 1944

Immediate cause of death Pneumothorax — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hayden G. MacDonald M. D.
Address 1313 Light St Date signed 9-15-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 180

G20864

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

159

Registered No. G20864

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or Institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days) D

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Pasadena Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Annapolis Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Forrest Franklin Hancker Twin #1

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-13-1944

8. AGE: Years	Months	Days	If less than one day
—	—	—	0 hr. 3 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Earl W. Hancker.
13. Birthplace West Virginia

MOTHER
14. Maiden Name Gladys Roberts
15. Birthplace Pennsylvania

16 (a) Informant Mrs. Gladys Hancker
(b) Address Pasadena Md.

17 (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location PUBLIC CEMETERY SEP 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 18 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-13 1944, at 2:09 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1944 to 9-13 1944, and that I last saw him alive on 9-13 1944.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles B. Nyestrand M. D.
Address 1213 Light St Date signed 9-17-44

G20865 ✓ G20865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 721 Harlem ave
(c) Hospital or institution: Baltimore md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H Naylor Naylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race cd

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 2 hr. 35 min.

9. Birthplace Baltimore md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank McKinley
13. Birthplace Newark Del

MOTHER
14. Maiden Name Nonine Mayto
15. Birthplace Frederick Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 18 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1944 at 6 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 14 1944 to Sept 14 1944 and that I last saw h.e alive on Sept 14 1944

Immediate cause of death: Pulmonary Edema

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 716 Bond Date signed 9/19/44 M. D.

2165

G20865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G20866

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene sts.
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30
(e) Length of stay in Baltimore (yrs., mos., or days) 30

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Molinsky

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/16/44

8. AGE: Years	Months	Days	If less than one day
		30	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name G. C. Wheeler
13. Birthplace Oklahoma

MOTHER
14. Maiden Name Anne Molinsky
15. Birthplace Pa

16 (a) Informant Anne Molinsky
(b) Address 435 E. North Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (Date rec'd by registrar) SEP 18 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-15-44 19 , at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1944 to 9-15 1944, and that I last saw him alive on 9-15 1944.

Immediate cause of death prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William D. Lynn M. D.
Address University Hosp. Date signed 9-15

VS 150

2166

G20867

JL - 83288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20867

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 1 - 29
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1832 N. Spring St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Taylor

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1895

8. AGE: Years 49 | Months 8 7 | Days 2 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Henry Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Susie Marthy
15. Birthplace Va.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 9-20-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Clem
(d) Location A. A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 SEP 19 1944 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1944, at 5:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9.13 1943, to 9/16 1944, and that I last saw h. alive on 9/16 1944.

Immediate cause of death — Duration

Chronic Pulmonary Tuberculosis ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Sauve

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Silas Halle

Address Balt. City Hosp Date signed 9/18/44
M D

G20868

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G20868 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) 20 Hours.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1673 N. Calhoun St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Angeline Summerville Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	married

6 (b) Name of husband or wife Albert Summerville

6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 7, 1894

8. AGE: Years	Months	Days	If less than one day
50	1	29	hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name William Bassett

13. Birthplace Va

MOTHER 14. Maiden Name Rose Robinson

15. Birthplace Va

16 (a) Informant John Lucas

(b) Address 1366 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (month) (day) (year)

(c) Cemetery or crematory St Peters Cem.

Location Md

18 (a) Funeral director George B. Kelson

(b) Address 1303 Pennsylvania Ave

19 (SEP 19 1944 Washington, D.C. Registrar)

MEDICAL CERTIFICATION

45

20. DATE OF DEATH Sept 16 1944, at 9 7 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute pulmonary edema

Due to Chronic myocardial degeneration

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Frataro M.D.
Medical Examiner.

Date signed Sept 17, 1944

VS 151

G20869 JOHNSON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1480

Registered No. G20869

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood or Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) ~~3 days~~ Johnson

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 521 N. Mount St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Lucille Johnson 532388

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles Johnson

6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 1917

8. AGE: Years 27 | Months | Days | If less than one day hr. min.

9. Birthplace Northumberland Co, Va. (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Nelson Jesse Jackson
13. Birthplace Va

MOTHER 14. Maiden Name Virginia Davis
15. Birthplace Va.

16 (a) Informant Lucille Johnson
(b) Address 521 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md

18 (a) Funeral director George S. Nelson
(b) Address 1303 Reustmans St

19 (a) SEP 19 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1944, at 7 05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1944 to 9-17 1944, and that I last saw her alive on 9-17 1944.

Immediate cause of death	Duration
Pulmonary Edema	
Due to Renal Insufficiency	
Due to Eclampsia	
Other Conditions Pregnancy	2 wks

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ethel Lyon, M. D.
Address Homewood Hospital Date signed 9-19-44

G20870

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 55E

G20870 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 4/22/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 4/22/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Mass. (b) County
(c) City or town Everett
(If outside city or town limits, write RURAL and give town)
(d) Street No. 69 Prescott Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NATHAN LELAND TILTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillis Tilton (Hopkins) 6 (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) June 1, 1896

8. AGE: Years	Months	Days	If less than one day
48	3	17	..... hr. ..... min.

9. Birthplace Chelsea, Mass.
(Town, county, and state)
10. Usual Occupation 1st Asst. Engineer
11. Industry or business Merchant Marine

FATHER
12. Name Nathan C. Tilton
13. Birthplace Lebanon, N. H.

MOTHER
14. Maiden Name Eva Cunningham
15. Birthplace Boston, Mass

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Sept 19-44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1612 Hollins St

19 (a) SEP 19 1944 (b) Harrington Williams M.D.

VS 150

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Sept. 18, 1944, at 7:37 M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr. 22, 1944 to Sept. 18, 1944 and that I last saw him alive on Sept. 18, 1944.

Immediate cause of death 1. Osteogenic sarcoma left upper femur with pathological fracture; 2. Multiple mets metastases of sarcoma of both lungs — Duration 1½ yrs. ago

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H C Tilton M. D.
Address Baltimore, Md. Date signed 9/18/44

MS-52496

C20871 (Aug)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

144a

C20871

89814

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

17

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 769 George St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Stanley

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Married

6 (b) Name of husband or wife Thurman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14th, 1904

8. AGE: Years	Months	Days	If less than one day
40	7	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Nathaniel Chinnage
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Green
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave [Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l. Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) (Informant) (b) Baltimore, Md. (Registrar)

SEP 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16, 1944 19 at 4.05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 19 44 to 9/16 19 44, and that I last saw h[illegible] alive on 9/16 19 44

Immediate cause of death: Pulmonary Edema — Duration 1 day
Due to Acute Cardiac Decompensation — 1 day
Due to H.B.P.D. and Eclampsia — 6 wks. 1 day.
Other Conditions Pregnancy, undelivered 8 months
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Donaldson Jr. M. D.
Address BCH Date signed 9/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G20872 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 d
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1627 W Lexington St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Bernice Lipscomb

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	M

6 (b) Name of husband or wife Sam Lipscomb
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1901

8. AGE: Years	Months	Days	If less than one day
43	5	10	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Rudolph Tripper
13. Birthplace Virginia

MOTHER
14. Maiden Name Wheatton Sammel
15. Birthplace Virginia

16 (a) Informant Samuel Lipscomb(H)
(b) Address 1627 W. Lexington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) SEP 19 1944 (Date rec'd by registrar) Huntington Hollidaysburg Pa. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/15 1944 at 8 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/19 1944 to 9/15 1944, and that I last saw h[illegible] alive on 9/15 1944

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Multiple Myelomas

Due to

Other Conditions Anemia.

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Gunther M.D.
Address Mercy Hosp Date signed 9/16/44

G20873
X1-88920

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20873 ✓ Registered No. 132

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1240 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos., 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 N. Bond Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Atkins

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2, 1922

8. AGE: Years	Months	Days	If less than one day
22	2	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Atkins
13. Birthplace Virginia

MOTHER
14. Maiden Name Susie Allen
15. Birthplace Virginia

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/44 (month) (day) (year)
(c) Cemetery or crematory Loth Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brant Ave

19 (a) (b) Huntington Mitchell Registrar
(Date rec'd by registrar)
SEP 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1944, at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 9/16 1944, and that I last saw h[illegible] alive on 9/16 1944.

Immediate cause of death — Duration

Chronic Pulmonary Tuberculosis ?

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elsie Hall
Address Balto City Hosp Date signed 9/18/44 M. D.

G20874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20874 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physician: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Haywood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Hayward Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Wheeler

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha B. Wheeler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1879

8. AGE: Years 65 | Months 6 | Days 9 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation Foreman (Road Const.)
11. Industry or business Road Const.

FATHER
12. Name Michael Wheeler
13. Birthplace Ireland.

MOTHER
14. Maiden Name Agnes Reifer
15. Birthplace Balto. Co. Md.

16 (a) Informant Mrs. Bertha B. Wheeler
(b) Address 3301 Haywood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leroy Boyle
(b) Address 5025 Belair Rd. Baltimore.

19 SEP 19 1944 (b) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17, 1944 at 9:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1944 to Sept 17 1944 and that I last saw h[illegible] alive on Sept 17 1944.

Immediate cause of death	Duration
(a) Coronary Thrombosis	1 hr.
Due to (b) Arteri Sclerosis	5 yrs.
Due to (c) Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury

23. Signature Charles J. Wheeler
Address 4276 Park Heights Date signed Sept 18 1944

G20875 ✓ G20875

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1825 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1825 W. Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Glyn C. Schaefer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edward F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24, 1919

8. AGE: Years	Months	Days	If less than one day
24	11	22	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Ray C. Thurston
13. Birthplace Virginia

MOTHER: 14. Maiden Name Janie McAlister
15. Birthplace Wyoming

16 (a) Informant Edward F. Schaefer
(b) Address 1825 W. Baltimore St

17 (a) ~~Burial~~ Removal (Burial, cremation, or removal) (b) Date thereof 9/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Maria
Location Charlestown W. Va.

18 (a) Funeral director Harry A. Winkler
(b) Address 401 E. Monument St.

19 (a) (Registrar) (b) Huntington Williams M.D. Registrar

SEP 19 1944

VS 1B

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 8:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Sept 16 1944
and that I last saw ~~had~~ alive on Sept 16 1944

Immediate cause of death: Carcinomatosis — Duration: 1 yr

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abbie H. Carnathan M. D.
Address 4709 Hood Ave Date signed 9-18-44

G20876

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G20876 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 S. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 S. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie K. Harrison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	widow

6 (b) Name of husband or wife late Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2 1859

8. AGE: Years	Months	Days	If less than one day
85	8	14	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Wm Hungerland
13. Birthplace Germany

MOTHER: 14. Maiden Name Wilhelmina Hildebrandt
15. Birthplace Germany

16 (a) Informant Jenkins-Freundel
(b) Address 1402 S. Carey St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/14/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Fredericks Rd

18 (a) Funeral director Harry A. Withey
(b) Address 4101 E Monument Ave

19 (a) SEP 15 1944 Huntington Williams, M.D. (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 9 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/27 19 44 to 9-16 19 44 and that I last saw h[illegible] alive on 9-16 19 44

Immediate cause of death: Bronchopneumonia — Duration 2 days
Due to Hardened arteriosclerosis
Due to Cerebrovascular Disease — 10 yrs
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

27. Signature Joseph G Lankenau M. D.
2 E Washington Ave Date signed 9/16/44

G20877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G20877 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1304 E Monument St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1304 E Monument St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ozella Mitchell

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Col.	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1910

8. AGE: Years	Months	Days	If less than one day
34			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace N C

MOTHER
14. Maiden Name Unknown
15. Birthplace N C

16 (a) Informant Willis Mitchell
(b) Address 1304 E. Monument

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co Md

18 (a) Funeral director Robert Fisher
(b) Address 1545 N Eden St

19 (a) SEP 19 1944 (Date received by Registrar) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14 1944 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Sept 14 1944 and that I last saw h.e alive on Sept 14 1944

Immediate cause of death — Duration

Pulmonary Tuberculosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Lapenta M. D.

Address 522 N. Broadway Date signed 9/19/44

G20878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G20878 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 702 Born Ct.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) H
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 N. Pine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Bowens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1897

8. AGE: Years	Months	Days	If less than one day
47	6	13	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Bowens
13. Birthplace Baltimore Maryland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Nellie Cassell Cousin
(b) Address 2602 Huron Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Olivet Cemetery
Location Baltimore County

18 (a) Funeral director Joseph A. Bively
(b) Address 1200 Mount Street

SEP 19 1944

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1944, at 8.29 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNabb M.D.
Medical Examiner.

Date signed 9/18/44

G20879

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

G20879 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1245 Hanbert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1245 Hanbert.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vergay Hurst

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17 1943

8. AGE: Years — | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Raymond O. Hurst
13. Birthplace Kentucky

MOTHER 14. Maiden Name Lizzie McFarland
15. Birthplace Kentucky

16 (a) Informant Raymond O. Hurst
(b) Address 1245 Hanbert St.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location South Baltimore Md

18 (a) Funeral director Flynn & Flemming
(b) Address 1426 Key Hwy

19 (a) (Date rec'd by registrar) Huntington Williams M.D.

SEP 19 1944

VS 10a

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1944 at AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1944 to Sept 19 1944 and that I last saw h alive on Sept 16 1944

Immediate cause of death Acute Gastro Enteritis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature O B Wheeler M. D.
Address 1279 Fulham N Date signed 9/19/44

C20880

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 748a

C20880 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 Liberty Hyte Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Middle River a.o Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 294 Rt. 14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carrie Christ

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wm. J. Christ
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1877

8. AGE: Years 67 | Months 5 | Days 16 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Charles Miller
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Wm. Earnest
(b) Address 14 E. Henrietta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cem.
Location 52nd O'Donnell St

18 (a) Funeral director Fred A. Frances & Sons
(b) Address 1216 E. Chas St.

19 (a) (Signature of local registrar) (b) Huntington Hillsdale, Md. (Registrar)

SEP 19 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 17 1944, at 6:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1944 to — 19—, and that I last saw her alive on Aug. 15 1944.

Immediate cause of death ? Diabetic coma
? anemia.

Duration

Due to Carcinoma cervix
Diabetes mellitus

Due to

Other Conditions Diabetes mellitus
Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Gilbert J. Vosburgh M. D.
Address Johns Hopkins Hospital Date signed

G20881 BALTIMORE CITY HEALTH DEPARTMENT G20881
Registered No.

CERTIFICATE OF DEATH 13a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 121 N. Amity St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Amity St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Jack Combs.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Col.	Widower

6 (b) Name of husband or wife Sarah Combs
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 31 87

8. AGE: Years	Months	Days	If less than one day hr.	min.
72	3	17		

9. Birthplace Linden Warren Co Va (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Junk & Store Co

MOTHER / FATHER
12. Name Unknown
13. Birthplace
14. Maiden Name Jemima Combs
15. Birthplace Linden Warren Co Va

16 (a) Informant Mary Bell Hill
(b) Address 121 N. Amity

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) SEP 19 1944 (Date rec'd by registrar) (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1944, at 10 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1942, to 9/17 1944, and that I last saw h[illegible] alive on 9/11 1944.

Immediate cause of death Cerebral apoplexy 3d attack
Due to Hypertension Nephritis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration 4 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Lawrence M.D.
Address 122 W Lee Date signed 9/18/44

G20882

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G20882
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 218 N Amity St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 218 N Amity St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: George Johnson

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) Mar 6 1904

8. AGE: Years 40 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Norfolk Va (Town, county, and state)

10. Usual Occupation House work

11. Industry or business

FATHER 12. Name Julius Waggoner

13. Birthplace Va

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Lawrence Murray

(b) Address 218 N. Amity St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 19 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) SEP 19 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sep 16 1944 at 10:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14/1944 to 9/16/1944 and that I last saw h[illegible] alive on 9/16/1944

Immediate cause of death	A	Duration
Coronary Occlusion		3 days
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Hoerlein M.D.

Address 10 N Carrollton Ave Date signed 9/19/44

G20883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G20883
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not use ditto marks. If unknown, write the words "unknown" or "not ascertained." Do not abbreviate. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 Druid Hill Ave (If rural, give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Leon Bracco

3 (b) If veteran, name war.....
3 (c) Social Security Account No.....

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife.....
6 (c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) June 3 1903

8. AGE: Years 41 | Months 3 | Days 13 | If less than one day .....hr. .....min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Eugene Bracco
13. Birthplace Maryland

MOTHER
14. Maiden Name Laura ?
15. Birthplace Maryland

16 (a) Informant Laura Bracco
(b) Address 805 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Maryland

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) SEP 19 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1944, at 3 20 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Concussion of Brain
Hypostatic pneumonia

Due to.....

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Septr 14, 1944 11/3 11 30 ? M.
(b) Where did injury occur? 805 Druid Hill Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? At home While at work? No
(d) Means of injury Fall down stairs

23. Signature Robert Le Gratten M.D.
Medical Examiner.
Date signed 9-19-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20884

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G20884
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 207 S. Castle St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 207 S. Castle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Everett W. Morgan

3 (b) If veteran, name war: N/o

3 (c) Social Security Account No. 216-14-0677

4. Sex: M

5. Color or race: W.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie V.

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Sept. 28, 1892

8. AGE: Years 51 | Months 11 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Queen Annes Co., Md.
(Town, county, and state)

10. Usual Occupation American Labor

11. Industry or business

FATHER
12. Name Hance Morgan
13. Birthplace Md.

MOTHER
14. Maiden Name Ella Dads
15. Birthplace Md.

16 (a) Informant Nellie V. Morgan
(b) Address 207 S. Castle St.

17 (a) Burial (b) Date thereof 7/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Christopher
Location Centreville, Md.

18 (a) Funeral director Martin W. E. Dippel's Sons
(b) Address Broadway & Ann St.

19 (a) SEP 19 1944 (Date rec'd by registrar) [illegible] Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 19 44, at 4 20 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature [illegible] M.D.
Medical Examiner.
Date signed 9/18/44

C20885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registration No. C20885

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 wk
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Geigan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife * * *
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 28 - 1881

8. AGE: Years	Months	Days	If less than one day
63	6	19	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation AT HOME
11. Industry or business * *

FATHER
12. Name John Geigan
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mary Garman
15. Birthplace Penna.

16 (a) Informant Mamie Geigan
(b) Address 820 E North Ave

17 (a) Burial (Burial, cremation, removal) (b) Date thereof Sep 21-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location OLD FREDERICK Rd

18 (a) Funeral director CHAS. F. EVANS & SON
(b) Address 618 W. Mt. Royal Ave

19 SEP 19 1944 (b) (Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 17 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/13 19 44 to 9/17 19 44 and that I last saw h[illegible] alive on 9/17 19 44

Immediate cause of death Coronary Thrombosis — Duration 6 wk

Due to Hypertension CVD — 3 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M James Foley M. D.
Address Mercy Hospital Date signed 9/19/44

G20886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46M

G20886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2107 Lyndhurst St.
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3204 Clifton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA W. ZEITLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: -

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 6, 1913

8. AGE: Years	Months	Days	If less than one day
30	11	12	hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual Occupation: Stenographer
11. Industry or business: Gas & Elec. Co.

FATHER
12. Name: Philip A. Hanigan
13. Birthplace: Glen Rock, Pa.

MOTHER
14. Maiden Name: Grace V. Wallemyer
15. Birthplace: Beckleysville, Pa.

16 (a) Informant: Mr. Philip A. Hanigan, Sr.
(b) Address: 3609 Mohawk Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1944, at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1943 to Sept 18 1944 and that I last saw h.e.r alive on Sept. 18 1944.

Immediate cause of death: H Sarcoma of B.I. Gland — Duration: 6 months?
Due to:
Due to:
Other Conditions: -
(Include pregnancy within 3 months of death)
Date of operation Aug. 1944
Major findings of operation: - Sarcoma. (Biopsy)
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: - Earl L. Chambers M. D.
Address 4108 Liberty Hts. Date signed 9/19/44

G20887

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 124B

G20887 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4303 Wendover Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill. (b) County
(c) City or town Chicago (If outside city or town limits, write RURAL and give town)
(d) Street No. 1963 Sunnyside Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARIE HOLMES LYDEN

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Carl Lyden
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 11/10/1888

8. AGE: Years	Months	Days	If less than one day
55	10	18	hr. min.

9. Birthplace: Worcester, Mass (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: John Holmes
13. Birthplace: Unknown

MOTHER
14. Maiden Name: Hahnah Nicholson
15. Birthplace: Unknown

16 (a) Informant: Mrs. Esther Holmes Bender
(b) Address: 4303 Wendover Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)
(c) Cemetery or crematory: Oakwood Cem.
Location: Waukegan, Ill.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 19 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1944, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from December 1943 to Sept. 18 1944; and that I last saw h.er alive on Sept. 18 1944.

Immediate cause of death	Duration
Pulmonary Edema	6 hours
Due to Hypertension	2 years
Due to	
Other Conditions Pernicious Carcinoma of the liver (Include pregnancy within 3 months of death)	4 yrs.

Date of operation 8/5/40
Major findings of operation: Exploratory Laparotomy
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry L. Hanson M. D.
Address 2 E. Pratt St. Date signed 9/19/44

G20888

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 12

G20888 Registered No.

X-88321

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.,16 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 [illegible] Central Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Maasberg

3 (b) If veteran, name war: A0
3 (c) Social Security Account No. 217-05-1728A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 24, 1877

8. AGE: Years	Months	Days	If less than one day
66	10	23	hr. min.

9. Birthplace Md.
10. Usual Occupation Watchman
11. Industry or business Tulips Gatman

FATHER
12. Name Gustave Maasberg
13. Birthplace Germany

MOTHER
14. Maiden Name Pauline Fisher
15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/44 (month) (day) (year)
(c) Cemetery or crematory Immanuel
Location Erindale Lane, Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 SEP 19 1944 [illegible] Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17, 1944, at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-1- 1944 to 9-17, 1944, and that I last saw him alive on 9-17- 1944.

Immediate cause of death: Ca. of prostate
Ca metastasis to bladder.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: Ca. prost. + bladder.
of autopsy: Same

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold E. Dalton
Address Balto. City Hosp. Date signed 9/18/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

G20889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

193a

Registered No. G20889

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1745 Jackson st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1745 Jackson st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilhelm ~~William C.~~ Schmidt

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of ~~husband or~~ wife Sadie Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9th 1870

8. AGE: Years	Months	Days	If less than one day
74	6	8	hr. min.

9. Birthplace Balto. Md.
(Town, county and state)
10. Usual Occupation Retired Railroader
11. Industry or business B & O R.R.

FATHER
12. Name Nichola Schmidt
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Benson
15. Birthplace France

16 (a) Informant Mrs. Loretta Rasch
(b) Address 3611 Gibbons Ave

17 (a) Burial (b) Date thereof 9/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto.
Location Md

18 (a) Funeral director William Cook Inc
(b) Address 1217 E. Paul St.

SEP 19 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17th 1944 at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1944, to Sept 17 1944, and that I last saw h~~e~~ alive on Sept 17 1944.

Immediate cause of death	Duration
Acute Myocarditis	11 days
Due to Chronic Broncitis	3 weeks
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature C. Mallett
Address 1279 Hillsdale Date signed 9/19/44 M. D.

~~PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.~~

~~MARGIN RESERVED FOR BINDING~~

G20890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G20890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1205 N. Potomac Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 305 S. Woodyear Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS ROETTGER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: None

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Caroline Roettger
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6/17/1862

8. AGE: Years 82 | Months 2 | Days 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: retired Carpenter
11. Industry or business: Crown Cork , Seal

FATHER
12. Name: August Roettger
13. Birthplace: Germany

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Edward Roettger
(b) Address: 2121 Sinclair Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-19-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Balto. Md.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) SEP 19 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH Sept 15 1944, at 11.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1 1944 to 9-15 1944.
and that I last saw h[illegible] alive on 9-12 1944

Immediate cause of death: Hypertension and Cerebral Hemorrhage — Duration 2 wks
Due to: Dilation of Heart
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Edward Roettger M.D.
Address: 2121 Sinclair Lane Date signed 9-19-44

G20891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131a

Registered No. G20891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please ease write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 E. 33rd Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 822 E. 33rd. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTHA MADELINE EYBS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Eybs
6 (c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1873

8. AGE: Years: 71 | Months: 7 | Days: 27 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Kirschke
13. Birthplace: Germany

MOTHER
14. Maiden Name: unknown
15. Birthplace:

16 (a) Informant: Mr. Joseph Eybs
(b) Address: 822 E. 33rd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9- 20-44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Avenue & Broadway

19 SEP 19 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1944 at 7.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 13 19 44 to Sept 16 19 44.
and that I last saw h.r alive on Sept 16 19 44.

Immediate cause of death: Cerebral Hemorrhage — Duration: 3 days
Due to: Cardio Renal Dis — 2 yrs.
Due to: Arteriosclerosis
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C N Hess & Son
Address 15 W E 32 St Date signed 9/20/44 M. D.

G20892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1482

G20892 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3901 E. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3901 E. Lombard St (If rural give location)
(e) If foreign born, how long in U. S. A.? years.

3 (a) FULL NAME Editha M. Montague

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	W	Married

6 (b) Name of husband or wife R. E. Montague
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 8/26/1892

8. AGE: Years	Months	Days	If less than one day
52		21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER 12. Name Daniel Stoltz
13. Birthplace Not

MOTHER 14. Maiden Name Not known
15. Birthplace Not known

16 (a) Informant Robert E. Montague
(b) Address 3901 E. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E. Northern ave

18 (a) Funeral director Henry Lutz
(b) Address 1203 N. Broadway

19 (Signature and title) Huntington Williams M.D.

SEP 19 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 17 1944 at 10 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9-5-44 to 9-17-44, and that I last saw him alive on 9-15-44

Immediate cause of death: Generalized Carcinoma

Due to: Carcinoma of Uterus

Due to:

Other Conditions: Metastases

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration: 14 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Fred Arnold M.D.
Address 700 N. Patterson Park Ave Date signed 9-18-44

G20893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 183

G20893

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flew Street
(c) Hospital or institution: 6

(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N. Glover Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Backowski

3 (b) If veteran, name war WWI #1

3 (c) Social Security Account No. 213-07-3622

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Bethlehem Steel Co

FATHER
12. Name Joseph Backowski
13. Birthplace Russia

MOTHER
14. Maiden Name ?
15. Birthplace Russia

16 (a) Informant John Bricka
(b) Address 3 N. Glover St

17 (a) Burial (b) Date thereof 9/21/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Ozmer & Son
(b) Address 1930 Eastern Ave

19 (a) (Date received by local registrar) SEP 19 1944 (b) Filing Deputy Registrar Baltimore, Md.

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18- 1944, at 9:30 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Found Drowned.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-17 at 1/1 P. M.
(b) Where did injury occur? Lake, Harbor, Foot of Ellwood Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
Means of injury Found Drowned

23. Signature Howard J. Walker M.D.
Medical Examiner.
Date signed 9-18-44

PRINT WRITE AND, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G20894 BALTIMORE CITY HEALTH DEPARTMENT G20894

CERTIFICATE OF DEATH 166

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Only correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp. D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 E Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Winston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 6, 1929

8. AGE: Years	Months	Days	If less than one day
15	5	10	hr. min.

9. Birthplace Wake Forest, N. C
(Town, county, and state)

10. Usual Occupation School Boy

11. Industry or business

FATHER
12. Name Thomas Winston
13. Birthplace N. C

MOTHER
14. Maiden Name Lula Keith
15. Birthplace N. C

16 (a) Informant Lula Winston
(b) Address 1302 E Lexington

17 (a) Burial (b) Date thereof 9/20/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Wake Forest N. C

18 (a) Funeral director Elroy O Wilson
(b) Address Grant & Bayard Ave

19 (a) (Date rec'd by registrar) SEP 19 1944 (b) Frederick, Md. Baltimore, Md.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1944, at 9 30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of chest

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 16 1944 9 15 P.M.
(b) Where did injury occur? Bond & Biddle Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury shot

23. Signature Robert Lee Fratter M.D.
Medical Examiner.
Date signed Sept 19 1944

G20895

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G20895 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 E. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walker Vernon Summerville

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-2-44

8. AGE: Years | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry Harford
13. Birthplace (Md)

MOTHER 14. Maiden Name Maggie Summerville
15. Birthplace (Md)

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHN HOPKINS MEDICAL SCHOOL SEP 20 1944

18 (a) Funeral director Commissioner of Health
(b) Address

SEP 19 1944 (Date rec'd by registrar) (b) [illegible] Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11- 1944, at 11.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1944 to 9-11- 1944, and that I last saw him alive on 9-11-1944

Immediate cause of death	Duration
Pneumonia	
Due to Prematurity	
Due to Malnourishment.	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address The Johns Hopkins Hosp Date signed 9-12-44

VS 180

2173

JL -89245 C20896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

C20896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 Shields Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

171

3 (a) FULL NAME Willette Coleman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1928

8. AGE: Years	Months	Days	If less than one day
16	7	25	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Clifton
13. Birthplace Md.

MOTHER
14. Maiden Name Elmira Chambers
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto Co. Md.
18 (a) Funeral director Chas. H. Alexander
(b) Address 922 N. Monroe St.
19 (a) (b)
(Date received) SEP 19 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1944, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8/4 1944 to 9/17 1944 and that I last saw h[illegible] alive on 9/17 1944

Immediate cause of death — Duration

Chronic Pulm. Tuberculosis — 2

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Balt City Hosp. Date signed 9/18/44

458616 G20897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V13B

Registered No. G20897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Baltimore.
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 14yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1549 Pealer St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No) If yes, name country.....

3 (a) FULL NAME Dellarese Goodman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 8-31-24

8. AGE: Years 20 | Months 19 | Days - | If less than one day ..... hr. ..... min. | 18

9. Birthplace Ga. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business

FATHER
12. Name Alfred Gibbs
13. Birthplace Ga.

MOTHER
14. Maiden Name Alice Rockard
15. Birthplace Ga

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem.
Location Halethorpe Md.

18 (a) Funeral director Chas H. Alexander
(b) Address 927 N. Monroe St.

19 (a) (Date rec'd by Registrar) SEP 19 1944 (b) Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1944, at 6.10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 3 1944, to Sept. 18 1944, and that I last saw her alive on Sept. 18 1944.

Immediate cause of death, Tuberculosis, Pulmonary, miliary. — Duration 6 weeks

Due to..... — Duration .....

Due to..... — Duration 1 year 4 mos.

Other Conditions Tuberculous Bronchitis

Date of operation May, 1944

Major findings of operation: Tuberculous Peritonitis

of autopsy: above.

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Margaret C. Andrews M. D.
Address Johns Hopkins Hospital Date signed 9-19-44

G20898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G20898 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2223 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas ~~Fenton~~ Lowe Dawson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-23-1885.

8. AGE: Years 59 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Bethlehem S.B.Co.

11. Industry or business

FATHER 12. Name William F. Dawson

13. Birthplace Md.

MOTHER 14. Maiden Name Emma C. Viers

15. Birthplace Rockville Md.

16 (a) Informant Mrs. Josephine D. Wootton

(b) Address Rockville Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory Beallsville Cem. [redacted]

Location

18 (a) Funeral director Reuben Dumphreys.

(b) Address Rockville.

19 (a) SEP 19 1944 (b) Huntington Williams M.D.
(Filed by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 16 1944, at 7 40 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac hypertrophy and dilatation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Gratton M.D.
Medical Examiner.

Date signed Sept 17 1944

(OVER)

G20899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G20899
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2221 Arden Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert L. Dashew

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Ruth Dashew

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1907

8. AGE: Years 37 | Months 7 | Days 18 | If less than one day ..... hr. ..... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business

FATHER
12. Name Jacob Dashew
13. Birthplace Russia

MOTHER
14. Maiden Name Eva Cherens
15. Birthplace Russia

16 (a) Informant Boris R. Dashew
(b) Address 2221 Arden Rd.

17. Cremation (b) Date thereof 9/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director Harold Sonneborn & Sons
(b) Address 1902 Eutaw Place

19 (a) SEP 19 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION 09

20. DATE OF DEATH Sept. 19, 1944, at 12 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-17-44 at 3 P. M. Balto. Co.
(b) Where did injury occur? Randallstown, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by auto.
23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed 9-19-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

[redacted] BALTIMORE CITY HEALTH DEPARTMENT

G20900 CERTIFICATE OF DEATH 1477 Registered No. G20900

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2007 Wilkens Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2007 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Philo Epefanio 38820

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anthony

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 14 1918

8. AGE: Years 25 | Months 9 10 | Days 264 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Claude Thompson
13. Birthplace Md

MOTHER
14. Maiden name Beatrice Wills
15. Birthplace Md

16 (a) Informant Anthony Epefanio
(b) Address 2007 Wilkens Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)

(c) Cemetery or crematory Catholic
Location Baltimore Md

18 (a) Funeral director Geo A Fahey
(b) Address Guilford & Lafayette

19 1944 Filed by registrar Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1944 at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1944 to Sept 18 1944, and that I last saw h[illegible] alive on Sept 18 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Childbirth — 8 days

m. 9-10-44
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carl London M. D.
Address 2201 W. North ave Date signed 9-19-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G20901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G20901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 d + Calvert
(c) Hospital or institution: U. M. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 202 9 Cecil Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs MARY BUCKLEY KELLY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. wid

6 (b) Name of husband or wife John Joseph Kelly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3 Nov 1870

8. AGE: Years 73 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name John Buckley
13. Birthplace Balto

MOTHER
14. Maiden Name Anna Hafey
15. Birthplace Balto

16 (a) Informant Miss E. Marie Pinning
(b) Address 3053 Guilford Av.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 201 E. 22nd St.

19 (a) SEP 20 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept. 1944 at 12 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 15 Sept. 1944 to 18 Sept. 1944. and that I last saw her alive on 18 Sept. 1944

Immediate cause of death Cardiac failure

Due to Hypertensive Cardio Vascular renal disease

Due to

Other Conditions Mammal anaemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanWilpo M. D.

Address Union Memorial Hosp Date signed 9-18-44

G20902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G20902

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1028 N. Fulton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew N. Symbouras

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ifigilia
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-1892

8. AGE: Years 52 | Months 7 | Days — | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Owner
11. Industry or business Restaurant

FATHER
12. Name Nicholas Symbouras
13. Birthplace Greece

MOTHER
14. Maiden Name Regina
15. Birthplace Greece

16 (a) Informant Nicholas Symbouras
(b) Address 737 N. Howard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-20-44 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox
Location Wingate Mill Rd.

18 (a) Funeral director Wm. Looby Inc.
(b) Address 1217 St. Paul St.

19 (a) SEP 20 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 18, 1944, at 1:40 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes mellitus
Coronary occlusion
Due to
Other Conditions Coronary thrombosis
Diabetes mellitus
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. F. Wollenweber M.D.
Medical Examiner.
Date signed September 19, 1944.

(Over)

G20903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91B

Registered No. G20903

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 515 W. Lexington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 W. Lexington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Voigt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband ~~or wife~~ Henry A. Voigt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27th 1880

8. AGE: Years 64 | Months 1 | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Henry A. Voigt
13. Birthplace Germany

MOTHER 14. Maiden Name Louisa Voigt
15. Birthplace Germany

16 (a) Informant Rev. Bruce McDonald
(b) Address 515 W. Fayette St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 9/22/44 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 SEP 20 1944 (Date rec'd by registrar) (b) Huntington Williamsport, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1944, at 5-30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 4 1944 to Sept 15 1944 and that I last saw h[illegible] alive on Sept 18 1944

Immediate cause of death	Duration
(a) Cerebral Embolism	3 mos.
Due to (b) Hypertension	3 mos.
Due to (c) Arteriosclerosis	-6 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C B Wheeler MD

Address 1279 Mulberry Date signed 9/19/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20904

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

448

Registered No. G20904

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 48 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 Dixie Drive
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Alice Hasbrouck

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: None

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: C. E. Hasbrouck
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-20-1903

8. AGE: Years	Months	Days	If less than one day
41	-	29	hr. min.

9. Birthplace Missouri (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at Home

FATHER
12. Name Henry F. Englehart
13. Birthplace Rockport N.Y.

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Zanesville Ohio

16 (a) Informant Chas. G. Hasbrouck
(b) Address Towson Md.

17 (a) Removal (b) Date thereof 9/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Riverside
Location Oshkosh, Wisconsin

18 (a) Funeral director William Bok Inc
(b) Address 217 St. Paul St

SEP 20 1944 (b) Huntington Williams, M.D.
(Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1944 at 11:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-30 1944 to 9-18 1944 and that I last saw h CR alive on 9-18 1944

Immediate cause of death: Cardio-Resp. failure

Due to: Hodgkins Disease

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanLill M.D.
Address Union Memorial Hosp Date signed 9-18-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G20905

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 758 Carroll Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary M. Hampton

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Charles Hampton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27 1870

8. AGE: Years 74 | Months 2 | Days 22 | If less than one day hr. min.

9. Birthplace Dorchester Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name (Unknown) McCrean
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Emerald Hornsberger
(b) Address 417 Yale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 S. Paca St

19 SEP 20 1944 (Date filed by registrar) (b) Thurlow Fox Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION 05

20. DATE OF DEATH September 9, 1944, at 7 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 21-1
(a) Date of injury 8 P.M. 9-18-44
(b) Where did injury occur? Wash. Blvd. & Bayview
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury pedestrian struck by auto

23. Signature T. L. Wallenmaier M.D. Medical Examiner.
Date signed 9-19-44

Please write plainly, with indelible pencil. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G20906 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County,
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 St. Paul Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Dennett Derwart

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Michael C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/16/1905

8. AGE: Years 39 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Leo. Jansenberg
13. Birthplace U.S.A.

MOTHER
14. Maiden Name Elizabeth J. Knapp
15. Birthplace Md. C. Derwart

16 (a) Informant Michael C. Derwart
(b) Address 2400 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Carmel
Location O'Donnell St

18 (a) Funeral director J. Ryck Hartford Ave
(b) Address 5305

19 (a) (Date received) SEP 20 1944 (Registrar) Harrington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1944, at 10:25 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Walker M.D.
Medical Examiner.
Date signed September 19, 1944.
(Coroner)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

✓ G20907 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3800 Towanda Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

15 5/12

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3800 Towanda Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Heyman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Morris Heyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER 12. Name Morris Aronoff
13. Birthplace Russia

MOTHER 14. Maiden Name Ida Aronoff
15. Birthplace Russia

16 (a) Informant Mrs Sara Heyman
(b) Address 3800 Towanda Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept, 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship Cemetery
Location Hamilton ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 SEP 20 1944 Washington Williams M.D. Registrar
Date received by Registrar

VS 150

MEDICAL CERTIFICATION

10.30

20. DATE OF DEATH September 18 1944 at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-18-1944 to Sept 18 1944, and that I last saw her alive on Sept-18-1944.

Immediate cause of death: Acute Pulmonary Edema — Duration: not known

Due to: Hypertension — Duration:

Due to: arteriosclerosis — Duration:

Other Conditions: Diabetes — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 1944 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Herman Seidel M. D.
Address 2404 Eutaw Pl Date signed 9/19/44

G20908 Cooper

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G20908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 E. Monument st
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Forrest Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Cooper

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1882

8. AGE: Years 62 | Months 4 | Days — | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Jacob Cooper
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Mendel
15. Birthplace Russia

16 (a) Informant Mrs. Rebecca Cooper
(b) Address 3618 Forrest Park ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 20/44 (month) (day) (year)
(c) Cemetery or crematory Wm Knabe & Co. Crale Annex
Location Mt Carmel Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 114-16 W. North ave

19 (a) (Signature) SEP 20 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18 1944, at 1130 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15 1944, to 9/18 1944 and that I last saw him alive on 9/18 1944

Immediate cause of death Cardiac Failure — Duration

Due to Coronary occlusion

Due to Arteriosclerotic H. disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Akman M. D.
Address Sinai Hosp. Date signed 9/18/44

G20909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 138

G20909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 N. Gilmor
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No 626 N. Gilmor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia Underwood Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed or divorced Married

6 (b) Name of husband or wife Felix Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18 1909

8. AGE: Years 35 | Months 7 | Days | If less than one day hr. min.

9. Birthplace Charlottesville Va
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Horace Davis
13. Birthplace Va

MOTHER
14. Maiden Name Virginia Sheppard
15. Birthplace Va

16 (a) Informant Betty Lou Preston
(b) Address 626 N. Gilmor St

17 (a) Burial (b) Date thereof Sept 22-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Charlottesville Va

18 (a) Funeral director Sam'l N. Chase & Son
(b) Address 638 N. Gilmor St

19 (a) SEP 20 1944 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1944 at 10 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1944 to Sept 19 1944 and that I last saw h. C. alive on Sept. 19 1944.

Immediate cause of death	Duration
Pulmonary Hemorrhage	5 days
Due to Kochs Infection (Primary Cause)	3 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Rodger W. Redding

Address 426 N. Gilmor St Date signed 9/19/44

C20910

TO #88726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

C20910 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 132 W. West St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marion Lesesne

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Irene
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 23, 1912

8. AGE: Years	Months	Days	If less than one day
32	3	25	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Lesesne
13. Birthplace South Carolina

MOTHER
14. Maiden Name Carrie Romalson
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/20/44 (month) (day) (year)
(c) Cemetery or crematory Hunter
Location S. C.

18 (a) Funeral director Isaiah L. Brown
(b) Address 1044 W Montgomery St

19 (a) SEP 20 1944 (b) Huntington Williams, M.D.

V8 180

MEDICAL CERTIFICATION

P

20. DATE OF DEATH September 18, 1944, at 2:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 27, 1944 to Sept. 18 1944, and that I last saw him alive on Sept. 18, 1944.

Immediate cause of death: Tuberculous Meningitis
Due to: Pulmonary Tuberculosis
Due to: advanced, Bilateral
Due to:
Other Conditions

Duration
One week ?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. M. Phillips
Address Balt. City Hosp. M. D.
Date signed 9-19-44

G20911

Delano

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G20911
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 808 Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs.) mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 808 Sharp Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DELANO Delano W. Cunningham

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Child

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 7, 1942

8. AGE: Years 2 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Eby Cunningham
13. Birthplace N C

MOTHER 14. Maiden Name Goldie Jackson
15. Birthplace Md

16 (a) Informant Goldie Cunningham
(b) Address 808 Sharp St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location L & L & G Md

18 (a) Funeral director Isaiah L Brown Son
(b) Address 10 E W Montgomery St

19 SEP 20 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18 1944, at 10, M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Sept 18 1944 and that I last saw her alive on Sept 17 44

Immediate cause of death Acute Gonulus
Due to (Primary)
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration 1 week

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 W Date signed 9/19/44

0912

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH

102

Registered No. G20912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out full the name of city or town, and do not use local or figure dates. Be sure that the age is correctly stated. Where the exact age is not known, the approximate age should be given. If the deceased was married, widowed, or divorced, the name of husband or wife should be given. If the deceased was a child, the name of father or mother should be given. Be sure that the cause of death is correctly stated, and that the statement regarding attendance is signed. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 39 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Glenburnie
(If outside city or town limits, write RURAL and give town)
(d) Street No. 405 Eighth St Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Lipine (LIPIN)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Mrs Helen Lipine

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1, 1911

8. AGE: Years 33 | Months 5 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name John Lipine
13. Birthplace Baltimore

MOTHER
14. Maiden Name Augusta Bouck
15. Birthplace Balto.

16 (a) Informant HELEN LIPIN
(b) Address 405 Eighth St. Rd Glenburnie

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 13-44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. A.A. Co.
Location

18 (a) Funeral director Bernard C Harke
(b) Address 121 E West St

19 SEP 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1944 at 3:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/11 1944 to 9/20 1944.
and that I last saw h alive on 9/19 1944.

Immediate cause of death Card. Fail.

Due to Uremia

Due to Malig. Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. N. Crosley
Address Mercy Hosp. Date signed 9/20

G20913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

G20913 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 535 Cambria Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 535 Cambria Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANDREW JOHN SOELLNER

3 (b) If veteran, name war: World War 1

3 (c) Social Security Account No. 216-07-9784

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Nellie Z. Soellner

6 (c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Nov. 4, 1890

8. AGE: Years 53 | Months 10 | Days 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Panzer Pickel Co

FATHER
12. Name: Unknown
13. Birthplace: "

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mrs. Nellie Z. Soellner
(b) Address: 535 Cambria Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 9-20-44 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Henry Sander & Sons, Inc
(b) Address: North Ave; & Broadway

19 (a) Date received: SEP 20 1944 (b) Registrar: Huntington Mitchell, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 18 1944, at 1.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4/28/1944 to 9/16/1944, and that I last saw him alive on 9/16/1944.

Immediate cause of death: Malignancy of lung — Duration: ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Harry Leichel, M.D.
Address: 1226 Hanover St. Date signed: 9/18/1944.

G20914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered G20914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Woodington Rd. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Clarence A. Straw

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	705-05-3686

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Homozelle
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15, 1882

8. AGE: Years	Months	Days	If less than one day,
62	6	4	hr. min.

9. Birthplace Maryland (Union Bridge) (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business B. & O. R. R.

FATHER
12. Name Wilson Straw
13. Birthplace Maryland

MOTHER
14. Maiden Name Emma Neighwig
15. Birthplace Pa.

16 (a) Informant Miss Lonah Straw
(b) Address 800 N. Woodington Rd. 29

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Local Registrar) (b) SEP 20 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1944 at 12 20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1944 to 9/19 1944, and that I last saw h/xx alive on 9/19 1944.

Immediate cause of death	Duration
Coronary thrombosis	
Due to	
Due to	
Other Conditions Bronchial asthma	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers
Address Md. Gen. Hosp. Date signed 9/19/44 M. D.

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20915
459054

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13B

G20915 No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1415 Ellamont St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard C. Gaylor
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-42

8. AGE: Years	Months	Days	If less than one day
2	6	3	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Louis J. Gaylor, Jr.
13. Birthplace Balto Md. Zelner

MOTHER
14. Maiden Name Anna K. Zelner
15. Birthplace Balto Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem
Location Balto. Md.

18 (a) Funeral director Wm. J. Dickener & Son
(b) Address Balto Md

19 (a) SEP 23 1944 (Date rec'd by registrar) (b) Huntingtown Williamsport, Md. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 19 1944 at 2.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug- 11 1944 to Sept 19 1944, and that I last saw him alive on Sept 19 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Miliary tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Elizabeth Conrad M. D.
Address The John Hopkins Hosp Date signed 9-19

G20916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G20916 Registered No.

Every item of information should be carefully supplied. Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be made in permanent ink. Physicians: please correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert
(c) Hospital or institution: Union Memorial Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23d.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2531 Brookfield Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Irene V. Robinson (Irene V. Robinson)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: f | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S.

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1906

8. AGE: Years 37 | Months 8 | Days 25 | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business

FATHER
12. Name Emanuel Robinson (D)
13. Birthplace Russia

MOTHER
14. Maiden Name Bessie Kohn (D)
15. Birthplace Russia

16 (a) Informant Mother
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/20/44 (month) (day) (year)
(c) Cemetery or crematory Bals. Hebrew
Location Balt., Md.

18 (a) Funeral director Reid Sonneborn & Sons
(b) Address 19 & Eutaw Place

19 SEP 20 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19-44 19__, at 10:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-28 1944 to 9-19 1944, and that I last saw h.e.r alive on 9-19 1944.

Immediate cause of death Cardio-Resp. Failure — Duration

Due to Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9-7-44

Major findings of operation: Brain tumor (Glioma) (Angioma)

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack C. Magan, M.D. M. D.
Address U.M.H. Date signed 9-19-44

G20917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

G20917 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1138 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 60 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME RAY HERMAN

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife HARRY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace RUSSIA (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name ABRAHAM HARRISON
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MARY
15. Birthplace RUSSIA

16 (a) Informant FAMILY RECORDS
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 9-20-44 (month) (day) (year)
(c) Cemetery or crematory HERRING RUN
Location Phila Rd. & Bowleys Lane

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto. St

19 (a) SEP 20 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17-44 19 , at 4:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15, 1944, to Sept. 17, 1944, and that I last saw her alive on Sept. 17, 1944.

Immediate cause of death Carcinoma
Metastasis to Liver, etc.
Duration about 6 months (History)

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathaniel Smith, M.D.
Address 1814 Eutaw Pl. Date signed 9/19/44

G20918 460328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

G20918 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: John Hopkins Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3200 Reighton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Ingber.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	married

6 (b) Name of husband or wife Pearl
6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) 9-15-85

8. AGE: Years	Months	Days	If less than one day
58	-	3	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Grocery Store
11. Industry or business

FATHER
12. Name Henry Ingber
13. Birthplace Russia

MOTHER
14. Maiden Name ? ?
15. Birthplace ? ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-20-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Belair Rd & Hoerbley Lane
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Pratt St
19 (a) SEP 20 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-15 1944, at 6.45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-5 1944 to Sept-15 1944, and that I last saw him alive on Sept-15 1944.

Immediate cause of death	Duration
Respiratory Obstruction	
Due to Empyema-bronchopleural fistula	1 mo.
Due to Post-op. complications following rt. pneumonectomy	
Other Conditions Bronchogenic Carcinoma	

(Include pregnancy within 3 months of death)
Date of operation June 29, 1944
Major findings of operation: Empyema-Bronchopleural fistula
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Geo. A. Lang M.D.
Address [illegible] Date signed 9/18

G20919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No. G20919

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond and Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Linden Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard E. Davidson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Agnes Davidson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 18-1891

8. AGE: Years	Months	Days	If less than one day
53	7	1	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Decorator
11. Industry or business

FATHER
12. Name Richard Davidson
13. Birthplace Scotland

MOTHER
14. Maiden Name Drusilla Ward
15. Birthplace Scotland

16 (a) Informant Agatha Davidson
(b) Address 2011 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 22 44 (month) (day) (year)
(c) Cemetery or crematory Maryland Mem. Park
Location Baltimore

18 (a) Funeral director Philip Herwig Sons
(b) Address 824 Orleans St

SEP 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1944, at 6.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12-1944, to 9-19-1944, and that I last saw him alive on 9-19-1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to Pulmonary tuberculosis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dean Pondolf M. D.
Address Admin. Hosp. 9-19-44 Date signed

VS 150

G20920 BALTIMORE CITY HEALTH DEPARTMENT X G20920
CERTIFICATE OF DEATH 148a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Edmondson (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rachel Tucker S32362

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ernest Tucker

6 (c) If alive, give age 34 years

7. Birth date of deceased (mo., day, yr.) 8-26-16

8. AGE: Years 28 Months 0 Days 23 If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Merrell True

13. Birthplace N. Y.

MOTHER 14. Maiden Name Anna Kelly

15. Birthplace N. Y.

16 (a) Informant Ernest Tucker.

(b) Address Edgewater, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-44 (month) (day) (year)

(c) Cemetery or crematory Forest Shepherd

Location Ellicott City Md.

18 (a) Funeral director F.C. Heimbetheimer

(b) Address Ellicott City Md

SEP 20 1944 (Date rec'd by registrar) (b) Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19/44 19 at 8:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/13 1944 to 9/19 1944 and that I last saw her alive on 9/19 19 44

Immediate cause of death Heart failure — Duration

Due to Uremia + Hypertension

Due to Marked Edema of pulmonary

Other Conditions

(Insert the pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Bryan M. D.

Address 1 Agnes Hosp Date signed 9/19/44

VS 180

G20921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G20921 / 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gane
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED: Anne
(a) State Md (b) County Annde
(c) City or town Riviera Beach
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME William C. Kelly

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 23-1869

8. AGE: Years 65 | Months 1 0 | Days 22 | If less than one day hr. — min. 1879

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Clerk Lunch Room

11. Industry or business

FATHER
12. Name James Kelly
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mary C. Lowman
15. Birthplace Balto Md

16 (a) Informant Mrs. Jas. F. Kelly
(b) Address 1208 Carroll St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21-44 (month) (day) (year)
(c) Cemetery or crematory [redacted]dow Park
Location Balto Md

18 (a) Funeral director Geo L. Boyer Jr
(b) Address Pollock St

19 SEP 20 1944 (Date rec'd by registrar) (b) —

Registrar

Robert Lee Fraley 2nd Stumbo Wife Married Dec 4 1943

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1944, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 6 1944 to Sept 19 1944, and that I last saw him alive on Sept 19 1944

Immediate cause of death: Pneumonia — Duration

Due to —

Due to —

Other Conditions Non-union fracture of Shaft of left leg
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operations: —

of autopsy: Laceration - Left Lobe

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature H. Gershenson M. D.
Address University Hosp Date signed Sept 19 1944

46055922

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G209222

Registered No. 46a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Wolfe.
(c) Hospital or institution:
Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Geo. (b) County
(c) City or town Augusta
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Montgomery Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male.	White	Married

6 (b) Name of husband or wife Edna.
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) 12-2-82

8. AGE: Years	Months	Days	If less than one day
61	9	17	hr. min.

9. Birthplace Geo.
(Town, county, and state)
10. Usual Occupation Yd Collector.
11. Industry or business

FATHER
12. Name John H Norris
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Haney
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9-23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West View Memorial Pk
Location Augusta, Ga.

18 (a) Funeral director Brinson-Byers
(b) Address 5005 Pitt St Phila Pa

19 (a) (b) Huntington Williams, M.D.

SEP 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-19- 1944, at 8:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13 1944, to 9-19 1944, and that I last saw him alive on 4-19 1944

Immediate cause of death Post op. Shock.

	Duration
Due to Operation	12 hrs
Due to	
Other Conditions Carcinoma of the esophagus. (Include pregnancy within 3 months of death)	

Date of operation 9-16-44 & 9-17-44
Major findings of operation: Ca of esophagus.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson
Address Johns Hopkins Date signed 9/18/44

G20923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20923 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway & Fairmount Ave.
(c) Hospital or institution: Church Home and Hospital
WO 4730
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 39 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rundall 32.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 820 Cromwell Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Thoma, Mrs. Margaret

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Thoma, Edgar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1904

8. AGE: Years 40 | Months 8 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Herbst, John L.
13. Birthplace Maryland

MOTHER 14. Maiden Name Uelmann, Adela
15. Birthplace Md

16 (a) Informant Hospital Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 22-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rood
Location Belair Rd.

18 (a) Funeral director John. J. Horan
(b) Address 3010 E. Balto. St.

19 (a) SEP 20 1944 Hastings Hillegeist
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18-1944, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1944, to 9-18-1944, and that I last saw her alive on 9-18-1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days
Due to: Hypertension — 12 yrs
Due to: Toxemia of Pregnancy — over
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harrison Latta M. D.
Address Church Home and Hosp'l Date signed 7-18-44

G20924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G20924 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1620 E. Chase Street
(c) Hospital or institution: 9 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 E. Chase Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary T. Mc Ginnity

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 19th, 1873

8. AGE: Years 70 | Months 9 | Days 0 | If less than one day: ###### hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Henry McGinnity
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Catherine Schonberger
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Barbara Wenzel
(b) Address 1620 E. Chase Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue, Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) SEP 20 1944 (Date rec'd by registrar) Huntington Williams, M.D. Address 1907 Eutaw Place

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 1944 to Sept. 19 1944, and that I last saw her alive on Sept. 19 1944.

Immediate cause of death: CEREBRAL HEMORRHAGE — Duration: 1 DAY
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry M. Rumbold, M. D.
Address 1907 Eutaw Place, Date signed 9-20-44

G20925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

Registered No. G20925

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1615 Shadyside Road (If rural give location) Naturalized
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Baby White

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-44

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Chester G White
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna Krastel
15. Birthplace Maryland

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location SEP 20 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 20 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-11 1944, at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1944, to 9-11 1944, and that I last saw him alive on 9-11 1944

Immediate cause of death Respiratory Failure — Duration

Due to Pulmonary Edema

Due to Erythroblastosis Foetalis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas L. Chipley M. D.
Address Union Memorial Hospital Date signed

2174 Hospital 9-16-44

G20926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G20926 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St
(c) Hospital or institution: President Home 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 70 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 W. Lafayette Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Middleton

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-10-5662

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	married

6 (b) Name of husband or wife Ethel Middleton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1889

8. AGE: Years	Months	Days	If less than one day
55	1	22	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name John Middleton
13. Birthplace Frederick Maryland

MOTHER
14. Maiden Name Ellen Griffin
15. Birthplace England Maryland

16 (a) Informant Ethel Middleton
(b) Address 1320 W. Lafayette ave

17 (a) Burial (b) Date thereof Sept 20, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph A. Seiby
(b) Address 400 N. Mount Street

19 (a) SEP 20 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1944, at 7:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-10- 1944 to 9-17- 1944, and that I last saw h/ alive on 9-17- 1944.

Immediate cause of death	Duration
Acute Dilatation of Stomach	
Due to Intestinal obstruction	
Due to Mass in Lung Intestine (Cancer)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 7-28-44
Major findings of operation: Dilated intestines
of autopsy: Ca. of Lung, Lung, Liver, Intestines (Adjacent)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R. L. Jackson M. D.
Address 1514 Division St. Date signed 9/20/44

G20927 G20927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V469

Registered No.

X4-89598

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

3-22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 840 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E. Stansbury

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1880

8. AGE: Years	Months	Days	If less than one day
64	-	2	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Edward Stansbury
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Myers
15. Birthplace Germany

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Sept 21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Wellsit Funeral Home
(b) 20 1944 2004 E. Oliver St
19 (a) (Huntington Williams M.D.)
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18 1944, at 11:50 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-31 1944 to 9-18 1944, and that I last saw him alive on 9-18 1944

Immediate cause of death	Duration
Pulmonary Infarct	2 days
Thrombophlebitis	25 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-8-44
Major findings of operation:
of autopsy: Above + Ca of pancreas

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Hanck E. Balton M. D.
Address Balt. City Hosp Date signed 9/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND RESERVED FOR RECORDING

G20928

G20928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 170C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital 6th
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 Jackson Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Holland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Marie Holland

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Aug 19 1894

8. AGE: Years	Months	Days	If less than one day
50	-	28	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Street Cleaning Dept

11. Industry or business

FATHER 12. Name Geo Holland

13. Birthplace Baltimore

MOTHER 14. Maiden Name Fanny Pierce

15. Birthplace Balto

16 (a) Informant Miss Agnes Holland

(b) Address 100 Jackson Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21 1944 (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem

Location City

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004 E Oliver St

(a) (Local registrar) (b) Hunter for Williams, M.D. Registrar

SEP 20 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17- 1944, at 2:00 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured skull

Due to

Other Conditions Fractured leg bones. Contusions abrasions & bruises
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-16-44 at 10:45 A.M.
(b) Where did injury occur? Phila. Rd - Mayfield Ave 26-4
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by automobile

23. Signature Howard J. Madden M.D.
Medical Examiner.

Date signed 9-18-44

G20929 ✓ G20929

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 92a
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2237 Mura St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days) 76 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2237 Mura St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME anna M. Kralicek

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Charles Kralicek
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22 1867

8. AGE: Years 76 | Months 11 | Days 27 | If less than one day hr. min.

9. Birthplace Hornwark
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Not known
13. Birthplace Bohemia

MOTHER
14. Maiden Name Not known
15. Birthplace Bohemia

16 (a) Informant Mrs. Mari Miller
(b) Address 2209 Mura St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md

18 (a) Funeral director Frank Brach Son
(b) Address 900 N. Chester St

19 (a) 9 21 1944 (Registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 18, 1944, at 10:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 16 1944 to Sept. 18 1944 and that I last saw her alive on Sept. 17 1944.

Immediate cause of death	Duration
Dilatation of heart	4 days.
Due to Aortic regurgitation	
Mitral stenosis	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ellen D. Fitzgerald M. D.
Address 613 E. Fayette Date signed 9-19-44

G20930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G20930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave.
(c) Hospital or institution: Lawndale - Edenwald Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs 4 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Rebecca Levine

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Late Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Jacob Kaufman
13. Birthplace Russia

MOTHER 14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Jacob Levine
(b) Address 7105 Arliane at

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21/44 (month) (day) (year)
(c) Cemetery or crematory Workmen Circle Cemetery
Location German Hill Road

18 (a) Funeral director Sol Levinson & Bros.
(b) Address 1124-26 W Northern

19 (a) (Signature of registrar) (b) Date received SEP 21 1944 Washington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1944 to 9-20 1944, and that I last saw h 9 alive on 9-20 1944

Immediate cause of death	Duration
Arteriosclerosis.	
Hypertension	
Due to	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edmund Levin M.D.
Address Lawndale Date signed 9/20/44

G20931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92N

Registered No. G20931

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3908 Maine Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

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2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 Maine Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMMA V. HARRISON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1865

8. AGE: Years 79 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Thomas H. Harrison
13. Birthplace Md.

MOTHER
14. Maiden Name Marie L. Beauchamp
15. Birthplace Md.

16 (a) Informant Miss Edith M. Harrison
(b) Address 3908 Maine Ave. 7

17 (a) Burial (b) Date thereof 9/22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

SEP 21 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20, 1944, at 1:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18, 1944, to Sept. 20, 1944, and that I last saw her alive on Sept. 18, 1944.

Immediate cause of death: Coronary occlusion — Duration: 2 hours

Due to: Chronic Endo. myocarditis — ?

Due to: arteriosclerosis with mild hypertension — ?

Other Conditions: Cataract & both eyes, visible 7 mos. — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Maurice S. Shannon M. D.

Address 3300 W. Forth Av. Date signed 9/21/44

G20932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 N

Registered No. G20932

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 d Calvert
(c) Hospital or institution: U. M. H
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 16
(d) Street No. 2503 Elsinore Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth A. Burger

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex f | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. wid

6 (b) Name of husband or wife John F. Burger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 Dec. 1873

8. AGE: Years 70 | Months 9 | Days 20 | If less than one day hr. min. 17

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Henry A. Henkel (?)
13. Birthplace Germany

MOTHER 14. Maiden Name Elizabeth A. Bekenwald
15. Birthplace Germany

16 (a) Informant Miss Louise A. Burger
(b) Address 2503 Elsinore Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 21 1944 (Date received by registrar) Hartington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 18 Sept. 1944 at 6-10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 17 Sept. 1944 to 18 Sept 1944. and that I last saw h[illegible] alive on 18 Sept 1944.

Immediate cause of death	Duration
Cardiorespir. failure	
Due to Cerebrovascular accident	
Due to Hypertensive Cardiovasc. Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.
Address U.M.H. Date signed 9-18-44

G20933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9Ha

G20933 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: 5219 Linden Heights Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5219 Linden Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles N. Rollings

3 (b) If veteran, name war: None

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1877

8. AGE: Years: 66 | Months: 9 | Days: 25 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Night Operator

11. Industry or business

FATHER
12. Name: James Rollings
13. Birthplace: --

MOTHER
14. Maiden Name: Margaret Scheirs
15. Birthplace: --

16 (a) Informant: Mrs. Rose E. Rollings
(b) Address: 5219 Linden Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)
(c) Cemetery or crematory: Moreland Memorial
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 SEP 21 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 1944, at 6 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept. 21 1944

G20934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47D

Registered No. G20934

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution:
St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

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2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3425 Liberty Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Elise Griere

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 213-05-9790

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1889

8. AGE: Years 55 | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business Balto. Transit Co.

FATHER
12. Name Dietrich Griese
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Stroecker
15. Birthplace Germany

16 (a) Informant Mrs. Anna M. Schmidt
(b) Address 1731 N. Chester St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 SEP 21 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1944 at 10 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1944 to 9/20 1944, and that I last saw her alive on 9/20 1944.

Immediate cause of death Cardiac failure — Duration

Due to Hypostatic CO Pneum

Due to

Other Conditions Metastic Carcinoma Lung
Adenocarcinoma
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Helen Griere
Address St. Joseph's Hosp. Date signed 9/20/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G20935

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eden and Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Bennett Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell Robinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Divorced

6 (b) Name of husband or wife Lena

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
37	—	—	hr. — min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business Beth. Steel Co.

FATHER
12. Name David Robinson
13. Birthplace Virginia

MOTHER
14. Maiden Name Roba Bagdin
15. Birthplace Virginia

16 (a) Informant Russell Robinson
(b) Address 937 Bennett Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Wright Co
Location Druid Ridge

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 32 N Fulton Ave

SEP 21 1944 (Date filed by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1944 at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1944, to 9/20 1944, and that I last saw h[illegible] alive on 9/19 1944.

Immediate cause of death	Duration
Resp. failure	1 min.
Due to Extreme cachexia	Gulsa
Due to Adv. Carcinoma tongue (Leukemia, Hodgkin's, Lymphosarcoma)	?
Other Conditions	?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Alfred I. Nelson, M. D.
Address University Hospital Date signed 9/20/44

G20936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G20936

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days):

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County: Baltimore
(c) City or town: Parkton, R.F.D. Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: ERNEST CALDWELL

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife: Jennie Caldwell
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.): Sept 13, 1894

8. AGE: Years	Months	Days	If less than one day
50	-	6	hr. min.

9. Birthplace: Indiana, Pa. (Town, county, and state)
10. Usual Occupation: Mail Carrier
11. Industry or business: U.S. Mail.

FATHER
12. Name: David Caldwell
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Ella Tuttle
15. Birthplace: Pa

16 (a) Informant: Jennie Caldwell
(b) Address: Parkton, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 22/44 (month) (day) (year)
(c) Cemetery or crematory: Stablersville
Location: Parkton, R.F.D. Md.

18 (a) Funeral director: Jacob Hartenstein
(b) Address: New Freedom Pa.

SEP 21 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH: September 19, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1944 to 9/19 1944, and that I last saw him alive on 9/19 1944.

Immediate cause of death: Lobar pneumonia, rt. upper lobe — Typhoid Pneumonia — Duration: 3 days

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Robert M. Parker M. D.
Address: Univ. Hosp. Date signed: 9/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

G20937 G20937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3953 Falls Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3953 Falls Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie Gibson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm. W. Gibson.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown.

8. AGE: Years	Months	Days	If less than one day
About 66			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Noah Martin.
13. Birthplace Md.

MOTHER
14. Maiden Name ? Merryman.
15. Birthplace Md.

16 (a) Informant Carroll Gibson.
(b) Address 3953 Falls Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 21, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Marys.
Location Hanover.

18 (a) Funeral director Almon Offt + Dameron.
(b) Address 3645-47 Eastern Ave.

19 (a) SEP 21 1944 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18, 1944, at 3:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Sept 18 1944 and that I last saw h[er] alive on Sept 17 1944.

Immediate cause of death: Cerebral Haemorrhage

Due to: Hypertension

Due to:

Other Conditions: Arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edw. R. Dameron D.
Address 4037 Falls Rd. Date signed 9/20/44

VS 150

AdCo. 5-11 2500

Tilden

G20938 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH

G20938

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Learmelton Ave St., Ward)

Length of residence in city or town where death occurred 16 yrs. ... mos. ... ds. How long in U.S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Francis E. Tildon

(a) Residence: No. 16 years St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	Colored	

6. If married, widowed, or divorced HUSBAND of (or) WIFE of

7. DATE OF BIRTH (month, day, year) 5/26/28

8. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	4	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, lawyer, bookkeeper, etc. School

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME Charles Tildon

14. BIRTHPLACE (city or town) (State or country) Md

MOTHER

15. MAIDEN NAME Elizabeth Grant

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Elizabeth Grant
(Address) 529 N. Carrollton Ave

18. BURIAL, CREMATION, OR REMOVAL
Place Catholic Date 9/23 19 44

19. UNDERTAKER Geo. F. Kelso
(Address) 1303 Pennsylvania Ave

20. FILED SEP 21 1944 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 19, 1944

22. I HEREBY CERTIFY, That I attended deceased from March 15, 1944 to Sept 19, 1944

I last saw h. alive on Sept 18, 1944 death is said to have occurred on the date stated above, at 9 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Tuberculosis	March 15 1944

Other contributory causes of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, how?

(Signed) H. Steinwand M.D.

(Address) 632 Fremont Ave

INFORMATION REGARDING THE CAUSE OF DEATH is required by law, and should be furnished by the person best acquainted with the facts. Exact statement of state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. OCCUPATION is very important.

G20939

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G20939 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 206 - N. Mechanic St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Pheobe Lloyd.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black.	

6 (b) Name of husband or wife Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 2 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Milton Linthicum
13. Birthplace Md.

MOTHER 14. Maiden Name Sadie ? ?
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9/23/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Wm. H. Kelly
(b) Address 1303 Pennsylvania Ave

19 (a) (Date received by Registrar) (b) REGISTRAR

VS 1944 SEP 21 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-20- 1944, at 6 02 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-19 1944, to Sept 20 1944, and that I last saw h.. alive on Sept 20 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of Stomach & carcinomatosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (specify type of place)
(e) Means of injury
23. Signature Abraham Linthicum
Address J. Hopkins Date signed 9-21-44

G20940

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93d

Registered No. G20940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 E Lough St.
(c) Hospital or institution: Sinai Hosp 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 1305 E. Lough St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lavereo Sollazzo
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Rose Sollazzo
6 (c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) Oct 18-1886
8. AGE: Years 60 | Months 11 | Days 1 | If less than one day: hr. min.
9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Bruno Sollazzo
13. Birthplace Italy

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Harry Talotta
(b) Address 513 W. Main St Cumberland
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23-44 (month) (day) (year)
(c) Cemetery or crematory Holy Soul
Location Carnegie Pa.
18 (a) Funeral director John C. Miller Inc.
(b) Address 1716 E. Oliver St

SEP 21 1944 (Date received by Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1944 at 2:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1944, to 9-17 1944, and that I last saw he alive on 9-15 1944.

Immediate cause of death: Ventricular fibrillation
Due to: Auricular fibrillation
Due to: Cardiac hypertrophy & dilatation
Other Conditions: Hypertension cardiovascular renal disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Hypertension C V D

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Myron J. Myers M. D.
Address Sinai Hospital Date signed 9-21-44

G20941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G20941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3407 Crossland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3407 Crossland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Margaret M. Stephens

3 (b) If veteran, name war /

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband William M. Stephens

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 2nd 1867

8. AGE: Years 77 | Months 7 | Days 16 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name (Unknown) Funk
13. Birthplace Germany

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Chas. L. Stephens
(b) Address 3407 Crossland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/21/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) Huntington Williams, M.D. (Registrar) Registrar

SEP 21 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 18th 1944 at 11:42 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 4, 1944, to Sept. 18, 1944, and that I last saw him alive on Sept. 18, 1944.

Immediate cause of death	Duration
Myocardial Failure	3 months
Due to Chronic Myocarditis	1 year
Due to ✓	
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation ✓
Major findings of operation: ✓
of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at ✓ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work? ✓ (Specify type of place)
(e) Means of injury ✓

23. Signature Frank M. Ogden.
Address 2701 N. Calvert St. Date signed Sept. 19, 44

G20942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G20942

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Mem. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 22 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla (b) County ?
(c) City or town West Palm Beach, Fla.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 - 43rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Clyde Otis Bates

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex Fml | 5. Color or race White | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife Mrs Clyde Otis Bates

wife

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Aug 11, 1897

8. AGE: Years 47 | Months 1 | Days 10 | If less than one day ....hr. ....min.

9. Birthplace Illinois
(Town, county, and state)

10. Usual Occupation Deaf clut attendant

11. Industry or business

FATHER
12. Name Henry Bates
13. Birthplace Illinois

MOTHER
14. Maiden Name Lulu Spalding
15. Birthplace Illinois

16 (a) Informant wife
(b) Address 515 - 43rd St. West Palm Beach

17 (a) Removal (b) Date thereof 9-22-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Jerseyville Ill.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) Filed by registrar SEP 21 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21, 1944 at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 31 1944 to Sept 21 1944, and that I last saw h. alive on Sept 20, 1944.

	Duration
Immediate cause of death Resp. failure.	Sunset
Due to Bronchopneumonia	1942
Due to Ulcerative Colitis.	
Other Conditions Malnutrition, debilitation and contracture	

(Include pregnancy within 3 months of death)

Date of operation 9-12-44

Major findings of operation: Ulcerative colitis

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanLill M.D.

Address Union Memorial Hosp. Date signed 9-31-44

G20943

G20943.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 526 S. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 526 S. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James E. Boland

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1890.

8. AGE: Years 53 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business B. & O. R. R.

FATHER
12. Name William Boland
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Anastatia Malone
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Howard E. Walker/sister
(b) Address 307 S. Mount St.

17 (a) Burial (b) Date thereof Sept. 22/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 4500 Old Frederick Rd.

18 (a) Funeral director Harry H. Mutake
(b) Address 101 Edmondson Ave. Baltimore, Md.

19 (a) SEP 21 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19/44. 19 at 11:2a M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/1 1944 to 9/19 1944
and that I last saw him alive on 9/13 1944

Immediate cause of death Coronary Embolism 8
Due to Endocarditis
Due to
Other Conditions Chronic Nephritis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature James E. Eisenhauer M.D.
Address 711 McMechen St Date signed 9/20/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No. G20944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2725 E.MADISON ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2725 E.MADISON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M.VELTE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: CHARLES A.VELTE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): FEB.15 1863

8. AGE: Years: 81 | Months: 7 | Days: 5 | If less than one day: hr. min.

9. Birthplace: BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER
12. Name: ADAM PFIFER
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: MARY WETERMAN
15. Birthplace: GERMANY

16 (a) Informant: PHILIP VELTE (SON)
(b) Address: 416 N.PATTERSON PARK AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT.23/44 (month) (day) (year)
(c) Cemetery or crematory: HOLY REDEEMER
Location: BELAIR ROAD

18 (a) Funeral director: Kelly & Zeelin Inc
(b) Address: 403 S.WOLFE ST.

19 (a) Date received: SEP 21 1944 (b) Registrar: Huntington Williams M.D. Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: SEPT.20 1944, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 20, 1944 to Sep. 20 1944, and that I last saw h[er] alive on Sep. 19, 1944

Immediate cause of death: Arterio sclerosis — Duration: 7

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Eugene L. Cavagnaro M. D.
Address: 514 Druid Lane Date signed: 9/20/44

G20945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1862 Registered No. G20945

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway and Fairmont
(c) Hospital or institution: Church Home and Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 9 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Church Home - Hospital (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Thornton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife Julius F. Thornton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6, 1856

8. AGE: Years	Months	Days	If less than one day
88	1	15	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michael Warner
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Julvina Rogers
15. Birthplace Baltimore, Md.

16 (a) Informant Hospital Records.
(b) Address Broadway & Fairmont

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Sept 23/1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd Baltimore Md

18 (a) Funeral director John O. Mitchell & Sons Co
(b) Address 1900 Eutaw Pl Baltimore, Md

SEP 21 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1944 at 9 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 2-28-1944, to 9-21-1944, and that I last saw h alive on 9-21-1944

Immediate cause of death: Lobar pneumonia — Duration 3 days
Due to: Fractured Femur, rt. — 7 wks
Due to: Fall
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 2-29-44
Major findings of operation: Pinning of hip
of autopsy: diverticulosis & pneumonia

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 2-28-44 at M
(c) Where did injury occur? Baltimore (City or town) Md (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury Tried to walk when alone. & fell
23. Signature Harrison Latta M.D. M. D.
Address Church Home & Hospital Date signed 9-21-44

VS 180 For St. H.L. Freeman by Howard J. Clemens, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 170C

G20946 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Patuxent PATUXENT
(If outside city or town limits, write RURAL and give town)
(d) Street No. U. S. Naval Station
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eugene J Gendron

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 077-09-3235

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Bertha Gendron

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 5, 1890

8. AGE: Years 54 | Months 6 | Days 15 | If less than one day hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Steam Fitter

11. Industry or business

FATHER
12. Name John E. Gendron
13. Birthplace Canada

MOTHER
14. Maiden Name Ida
15. Birthplace New York

16 (a) Informant Mrs. Bertha Gendron
(b) Address 29 Greene St. Huntington

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)
(c) Cemetery or crematory St. Peters Cem.
Location Plattsburg Clinton Co, NY

18 (a) Funeral director Phillip Hennigan
(b) Address 2024 Orleans St.

19 (a) SEP 21 1944 (Date received by registrar) Washington Williams II Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1944, at 6 10 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 19 1944 11/2 5 AM.
(b) Where did injury occur? Charles & 3rd Royal Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury pedestrian struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 20 1944

G20947

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20947 Registered No. 1358

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 105 N. FRONT ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sophie Silverberg
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife WOLF
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1899
8. AGE: Years 47 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name Joseph
13. Birthplace Russia

MOTHER
14. Maiden Name Yetta
15. Birthplace Russia

16 (a) Informant Husband
(b) Address
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski & Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

SEP 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1944, at G A M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1944, to 9/21 1944, and that I last saw h[illegible] alive on 9/21 1944

Immediate cause of death	Duration
(a) Myocarditis	
fatal	
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions Chronic hypertension and edema of left thigh.	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: not accountable

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? no While at work? (Specify type of place)
(e) Means of injury
23. Signature Jacob Lebenbe M. D.
Address Sinai Hospital Date signed 9/21/44

G20948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G20948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Valley at Preston St
(c) Hospital or institution: Little Sisters of the Poor
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 Dalley Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth M. Lowenstein

3 (b) If veteran, name war: No
(c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Charles D. J. Lowenstein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 30 1867

8. AGE: Years	Months	Days	If less than one day
77	7	19	hr. min.

9. Birthplace: Baltimore Md. (Town, county, and state)
10. Usual Occupation: Retired
11. Industry or business: Housewife

FATHER
12. Name: John Reinsfelder
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara Reid
15. Birthplace: Germany

16 (a) Informant: Mrs. Margaret M. McGuire
(b) Address: 1416 Dalley Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 22/44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral Cemetery
Location: 4300 Old Frederick Rd

18 (a) Funeral director: Lehnen & Conflenny Bros.
(b) Address: 924 E. Eager St.

19 SEP 22 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19th 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 1 1944, to Sept 19 1944, and that I last saw her alive on Sept 18 1944.

Immediate cause of death	Duration
Edema of Lungs	1 day
Due to Carcinoma Rt Ear	1 year
Due to	
Other Conditions Carcinomatosis	6 months

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Le Gill Hall M. D.
Address 1631 E. North Ave Date signed Sept 21 44

G20949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

109

Registered No. G20949

G20949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 Light St.
(c) Hospital or institution:
South Balt. Gen.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 1 da.

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County Dist.
(c) City or town Balto. Brooklyn
(If outside city or town limits write RURAL and give town)
(d) Street No. 220 Southern Rd
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank A. Gaston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6-1943

8. AGE: Years 1 | Months 4 16 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank W. Gaston
13. Birthplace New York

MOTHER
14. Maiden Name Mertie B Wetzel
15. Birthplace W. Va

16 (a) Informant Frank W. Gaston
(b) Address Laurel Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)

(c) Cemetery or crematory Ivy Hill
Location Laurel Md

18 (a) Funeral director Lloyd Kaiser
(b) Address Laurel Md

19 (a) [illegible] (b) Thurlington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1944, at 4 44 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1944 to 9-21 1944, and that I last saw h[illegible] alive on 9-21 1944.

Immediate cause of death
Pneumonia
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

over

Date of operation
Major findings of operation:
of autopsy: Pneumonia & edema of brain

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mertie B Wetzel M. D.
Address 131 Light St Date signed 9-22-44

C620950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. C620950

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1340 James St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 D
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1340 James St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman R. Wingate

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Ora V. Wingate
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1890

8. AGE: Years	Months	Days	If less than one day
54	-	18	..... hr. ..... min.

9. Birthplace Taylors Island, Md.
(Town, county, and state)
10. Usual Occupation Foreman
11. Industry or business Md. State Roads

FATHER
12. Name Frank Wingate
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Spedden
15. Birthplace Maryland

16 (a) Informant Mrs Ora V. Wingate
(b) Address 1540 James St.

17 (a) Burial (b) Date thereof Sept.22.1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director Frederick A. Cole
(b) Address 1200 W. Lombard St.

SEP 22 1944 (Date rec'd by registrar) Huntingtown, Williams, Md. (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19, 1944 at 2:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Sept 19 1944 and that I last saw him alive on Sept 19 1944.

Immediate cause of death	Duration
Cerebral Hemmorrhage	2 Weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Schield
Address 2301 Annapolis Rd. Date signed 9/21/44

VS 150

G20951

BALTIMORE CITY HEALTH DEPARTMENT ✓

CERTIFICATE OF DEATH 119a

G20951 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARG... RESERVED FOR H... ING

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 23rd
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 133 W. Hennetta St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Glenda Crawford ✓

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 - 43

8. AGE: Years | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Leo Crawford
13. Birthplace Ga

MOTHER 14. Maiden Name Fannie Davis
15. Birthplace S C

16 (a) Informant Fannie Crawford
(b) Address 133 W Hennetta St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co Md

18 (a) Funeral director Isaac L Rosenblum
(b) Address 1080 W Montgomery St

19 (a) SEP 22 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 19 44 at 8.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 19 44 to Sept 19 19 44 and that I last saw h[illegible] alive on Sept 19 19 44.

Immediate cause of death	Duration
Acute Gastro-enteritis	
Due to	
Due to	
Other Conditions Malnutrition	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 9/19/44

G20952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G20952 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 N.Rose St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 N.Rose St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tresa Ponzillo

3 (b) If veteran, name war ---
3 (c) Social Security Account No. ---

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Joseph Ponzillo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) -- 1873

8. AGE: Years 71 | Months | Days | If less than one day hr. min.

9. Birthplace Itlay (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Itlay

MOTHER
14. Maiden Name Unknown
15. Birthplace Itlay

16 (a) Informant Mr.Joseph Ponzillo
(b) Address 100 N.Rose St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept.23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redemeer Cem
Location Balto.Md.

18 (a) Funeral director Philip Henrig Sons
(b) Address 2024 Orleans St.

19 (a) SEP 22 1944 Registrar

Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept.20/44 1944, at 7.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 2 1944, to 9/20 1944, and that I last saw h.e. alive on 9/20/ 1944

Immediate cause of death: Cerebral Embolism / Heart — Duration

Due to: Cardio Vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Tankin M. D.
Address 100 N Gilmor Date signed 9/22/44

G20953 BALTIMORE CITY HEALTH DEPARTMENT G20953
CERTIFICATE OF DEATH 13a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1136 N. Carey St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) — 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1136 N. Carey St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Cornish Young
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed or divorced.
6 (b) Name of husband or wife Frederick Young
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) 1882
8. AGE: Years 62 | Months | Days | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Levi Cornish
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Minter
15. Birthplace Maryland

16 (a) Informant Mrs. J. Young
(b) Address 1136 N. Carey St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location
18 (a) Funeral director James A. Hayes
(b) Address 142 W. 7th St
19 (a) SEP 22 1944 Huntington Maryland

MEDICAL CERTIFICATION
20. DATE OF DEATH Sept 20 1944, at 1 45 M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Sept 20 1944, and that I last saw h[illegible] alive on Sept. 20 1944.

Immediate cause of death	Duration
(a) Uremia	1 week
Due to (b) Hypertensive Cardiovascular Renal Disease	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Ralph W Rackliffe
Address 426 N Johns St Date signed 9/22/44

VS 150

G20954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G20954 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Stat.
(c) Hospital or institution: South Baltimore General Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 90 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3944 Cloverhill Road.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Kimpel CHARLES FRANKLIN KIMPEL, Sr.

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mollie Schueler Kimpel
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 11, 1854

8. AGE: Years: 90 | Months: 9 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business: Tobacco Merchant

FATHER
12. Name: George Kimpel
13. Birthplace: Germany

MOTHER
14. Maiden Name: Margaret Lenzer
15. Birthplace: Germany

16 (a) Informant: Mr. Milton Schlutter
(b) Address: 3944 Cloverhill Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 (a) SEP 22 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-19 1944, at 6 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1944, to 9-19 1944, and that I last saw h/m alive on 9-17 1944.

Immediate cause of death	Duration
Bronchial Pneumonia	
Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles P. MacDonald M. D.
Address 1213 Light St Date signed 9-19-44

G20955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G20955 Registered No.

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME [redacted] Mc Glone Charles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1858

8. AGE: Years	Months	Days	If less than one day
86	-	19	hr. min.

9. Birthplace Phila (Town, county, and state)
10. Usual Occupation ✓
11. Industry or business -

FATHER
12. Name John Mc Glone
13. Birthplace Ireland

MOTHER
14. Maiden Name Susanne Sweeney
15. Birthplace Ireland

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rulo Wendfeld
(b) Address 914 Gunnon Court

19 (a) (b) Huntington Williams, M.D.

SEP 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1944, at 4 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Sept 21 1944, and that I last saw him alive on Sept 21 1944.

Immediate cause of death	Duration
Edema Lungs	3 days
Due to Chronic Myocarditis	4 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Gull Hall M. D.
Address 1631 E. North Ave Date signed Sept 22-44

G20956 ✓ G20956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 142B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 810 W. Lombard St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18-3

(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 810 W. Lombard St
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Margaret V. Wilson

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Charles Wilson

6 (c) If alive, give age 24 years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1920

8. AGE: Years	Months	Days	If less than one day
24	0	6	hr. min.

9. Birthplace Broadway, Va
(Town, county, and state)

10. Usual Occupation house work

11. Industry or business at home

FATHER
12. Name Unknown
13. Birthplace Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Va

16 (a) Informant Mr. Charles Wilson
(b) Address 810 W. Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location 2930 Edgevale Ave.

18 (a) Funeral director John J Gowan & Son
(b) Address 901-03 Hollins St

19 (a) SEP 22 1944 (Date Received) Registrar

VE 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21, 1944 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Ectopic pregnancy — Duration 2 hrs

Due to

Due to

Other Conditions Tubal rupture — Duration Hrs

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Glassman M. D.

Address 2607 Underwood Rd. Date signed Sept 22 1944

G20957 SKILLERN

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

G20957 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3320 Calvert
(c) Hospital or institution: U. M. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 12-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Home for Incurables (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Miss Shirley Elizabeth Skillern

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 31 1881

8. AGE: Years	Months	Days	If less than one day
62	10	18	hr. min.

9. Birthplace Philadelphia Tennessee (Town, county, and state)
10. Usual Occupation Retired nurse.
11. Industry or business

FATHER
12. Name James Anderson Skillern
13. Birthplace Tenn.

MOTHER
14. Maiden Name Ida Belle Caldwell
15. Birthplace Tenn.

16 (a) Informant Home for Incurables
(b) Address 40th & Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Huntington Williams M.D. (Registrar)
SEP 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1944 at 3 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1944 to Sept 21 1944 and that I last saw her alive on Sept 21 1944

Immediate cause of death	Duration
Cardiac - Resp. Failure	
Due to Appendicitis? Intestinal Obstruction?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George W. Musgrave Jr. M. D.
Address 332 E. Lanvale St. Date signed 9/24/44

G20958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

Registered No. G20958

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 40th St & Kenwood Rd.

(c) Hospital or institution: Home for Incurables 12 days

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 6 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto, Md.
(If outside city or town limits, write RURAL and give town)

(d) Street No. Home for Incurables
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary J Thompson

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan. 5 - 1878.

8. AGE: Years 66 yrs. Months 6 mos. Days 12 days. If less than one day ____ hr. ____ min.

9. Birthplace Howard County, Md.
(Town, county, and state)

10. Usual Occupation Secretary (retired)

11. Industry or business

FATHER 12. Name Samuel J Thompson

FATHER 13. Birthplace Howard County, Md.

MOTHER 14. Maiden Name Sarah E. Barnes

MOTHER 15. Birthplace Howard County, Md.

16 (a) Informant Records, Home for Incurables

(b) Address 40th St. Kenwood Rd Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)

(c) Cemetery or crematory Trinity Cem.

Location Pfeiffer's Corner, Howard Co.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) Date received SEP 22 1944 (b) [signature] Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20, 1944, at 9:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 14 1942 to Sept 20 1944, and that I last saw him alive on Sept 20 1944

	Duration
Immediate cause of death: Congestive Heart Failure (Acute)	5 days
Due to: Coronary Thrombosis	5 days
Due to: Arteriosclerotic Cardio-Vascular Disease	Several years
Other Conditions: Arteriosclerosis	several years

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas Conrad Williams M.D.

Address 11 E. Chase St. Date signed 9/22/44

Baltimore 2-MD.

~~20959~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C20959

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 E. Read St.
(c) Hospital or institution:
Avon Apts. 11-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 E. Read St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JAMES B. SCHAALE

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	213-01-1988

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Carrie M. Schaale
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 16, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	5	hr. min.

9. Birthplace York, Pa. (Town, county, and state)
10. Usual Occupation Manager
11. Industry or business Stout & Co.

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Signature received by registrar (c) 10 A.M. (b) Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1944, at 7:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 22nd 1944, to Sept 21 1944, and that I last saw him alive on Sept 20 1944

Immediate cause of death	Duration
Pulmonary Oedema	1 day
Due to Myocardial Degeneration	One
Cardiac Hypertrophy	year
Due to Arteriosclerosis	
Other Conditions Hypertension + Enlarged Heart	Many months

(Include pregnancy within 3 months of death)
Date of operation no
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at — M
(c) Where did injury occur? no
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —
23. Signature H. H. Ris M. D.
Address 24 S. Broadway Date signed Sept 21/44

0960

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G20960
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1827 Aisquith St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET JANE WAMHOFF

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Frank B. Wamhoff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1867

8. AGE: Years	Months	Days	If less than one day
76	10	11	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Matthew Snee
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret Gauvey
15. Birthplace -- Ireland

16 (a) Informant Mr. James M. Wamhoff
(b) Address 1827 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 22 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1944, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Sept 21 1944 and that I last saw h-- alive on Sept 20 1944.

Immediate cause of death Chr. Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Lowney M.D.
Address 441 N. Edward St Date signed 9/22/44

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Duplicate

G20961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G20961 Registered No. 94a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fulkens + Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City (If outside city or town limits, write RURAL and give town)
(d) Street No. Frederick Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Anna Phelps

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed or divorced married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Harry Beatty
13. Birthplace Md

MOTHER 14. Maiden Name Mgt. Flaggan
15. Birthplace Md

16 (a) Informant Margt Rinehart
(b) Address

17 (a) Burial (b) Date thereof 9-23-44 (month) (day) (year)
(burial, cremation, or removal)
(c) Cemetery or crematory Cathedral
Location Balto Md

18 (a) Funeral director Geo A Talley
(b) Address Baltimore Md

19 (a) SEP 22 1944 Huntington Williams, M.D.
(Date received by registrar)

VS 350

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1944 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 19XX to 9/20 19XX and that I last saw h[illegible] alive on 9/20 19XX.

Immediate cause of death Acute heart failure | Duration

Due to Myocarditis ruptured heart | Duration

Due to Coronary thrombosis + myocardial infarction | Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryson
Address St Agnes Hosp Date signed 9/20/44

433743 G20962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G20962 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4805 Gwynn Oak, Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard R. Gilbert Sr.
3 (b) If veteran, name war
3 (c) Social Security Account No. 239-09-5797

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ethel E.
6 (c) If alive, give age 64 years
7. Birth date of deceased (mo., day, yr.) 3-11-78

8. AGE: Years	Months	Days	If less than one day
66	6	10	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Service Technician
11. Industry or business Glen L. Martin
FATHER 12. Name James L. Gilbert
13. Birthplace Md.
MOTHER 14. Maiden Name Emma Kaufman
15. Birthplace Md.
16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23/1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md.
18 (a) Funeral director Harry A. Amacost
(b) Address 4204 Edgewood Ave
19 (a) (Date rec'd by registrar) (b) Registrar
SEP 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH Sept. 21 1944, at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 27 1943, to Sept 21 1944, and that I last saw h[illegible] alive on Sept. 21 1944.

Immediate cause of death	Uraemia	
Due to	Carcinoma of prostate & metastases	
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Joseph C. Bresti M. D.
Address Johns Hopkins Hosp. signed 9-24-44

G20963

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1579

G20963 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

MARG

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Aves.

(c) Hospital or institution: St Agnes Hospital 9-23

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days

(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 3720 Reisterstown Rd. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Crumlish

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18-1944

8. AGE: Years	Months	Days	If less than one day
		3	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name John J. Crumlish

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Frances Schabecq

MOTHER 15. Birthplace Md.

16 (a) Informant Mr. John J. Crumlish

(b) Address 3726 Reisterstown Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross Cemetery

Location Baltimore, Md.

18 (a) Funeral director H. W. Measelow

(b) Address 605 N. Calvert St.

19 (a) (Date received by registrar) (b) Registrar

VS SEP 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1944 at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1944 to 9/21 1944 and that I last saw h[illegible] alive on 9-21 1944

Immediate cause of death Starvation

Due to Congenital atresia of large intestine

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wilkens & Caton Aves Date signed 9/21/44

Address St Agnes Hosp

G20964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161c

G20964 Registered No.

MAKE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1525 Newkirk Rd
(Rural location)
(e) Citizen of foreign country? Bucks Co Pa (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Bert (MARY EILEEN)

3 (b) If veteran, name war —

3 (c) Social Security Account No. [illegible]

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19 1944

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert W Bert
13. Birthplace Balto Md

MOTHER
14. Maiden Name Mrs. Mary Bert
15. Birthplace Balto Md

16 (a) Informant Chart
(b) Address St Josephs

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/22/44

(c) Cemetery or crematory Loudon Park Cem Co
Location Baltimore Md

18 (a) Funeral director Wilson Corkran
(b) Address 1217 Park Ave
(Undertaker or person acting as such)

19 (a) (Date rec'd by Local Registrar) SEP 22 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 19 44 to 9/20 19 44 and that I last saw h[illegible] alive on 9/20 19 44

Immediate cause of death Streptococcal Bacteremia
Due to fetalis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Gilbert E Edwards M.D.
Address St Josephs Hosp Date signed 9/21/44

G20965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G20965 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1827 N. Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: E. Blanche Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, ~~widowed~~ or divorced: Married

6 (b) Name of husband: Fielding L. Watkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11 1895

8. AGE: Years 49 | Months 9 | Days 9 | If less than one day hr. min.

9. Birthplace Salem, Mass. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business at Home

MOTHER / FATHER

12. Name Alfred Hayes

13. Birthplace U. S.

14. Maiden Name Alice Kiff

15. Birthplace Mass

16 (a) Informant Fielding L. Watkins

(b) Address 1827 N. Milton Ave

17 (a) Burial (Burial, ~~cremation, or removal~~) (b) Date thereof 9/23/44 (month) (day) (year)

(c) Cemetery Moseland Memorial Park

Location Parkville Md.

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St.

19 (a) Date received (month, day, year) SEP 22 1944 (b) Filed by Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20/44 19 , at 12:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19/44 19 , to 9/20/44 19 , and that I last saw her alive on 9/20/44 19 .

Immediate cause of death: Cerebral Embolus — Duration:

Due to: Auricular Fibrillation

Due to: Rheumatic Heart Disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Julius Gluck M. D.

Address Franklin Sq. Hosp. Date signed 9/20/44

(OVER)

G20966 ✓ G20966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

Registered No.

IO #89775

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1907

8. AGE: Years 36 | Months 11 | Days -1- | If less than one day hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Little (d)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lizzie Ritson (d)
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie A. Williams
(b) Address 322 N Schroeder St.

19 (a) (b) Huntington Maryland
(Date rec'd by registrar) SEP 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1944, at 9:09 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13, 1944, to Sept. 19 1944, and that I last saw him alive on Sept. 19, 1944.

Immediate cause of death: Pulmonary Embolism — Duration: Instant

Due to: Acute Heart Disease = aortic insufficiency — Duration: ?

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle
Address Balt City Hosp. Date signed 9/20/44 D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Pollack

G20967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G20967

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Joseph's Hosp.
(c) Hospital or institution Catholic Sisters
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Armstead Gardens
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 Quantrill Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Pollock #1

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/44

8. AGE: Years	Months	Days	If less than one day
		13	hr. min.

9. Birthplace Balto- Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name George Pollock
13. Birthplace Penna

MOTHER
14. Maiden Name Mary Bigler
15. Birthplace Penna

16 (a) Informant George Pollock
(b) Address 920 Quantrill Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Security Blvd. Rd.

18 (a) Funeral director Lilly & Burbage
(b) Address 403 W. Lexington St.

19 SEP 22 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 19 44 at 4:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 19 44 to 9/22 19 44 and that I last saw him alive on 9/22 19 44.

Immediate cause of death Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D.

Address 4 E. Lexington St. Date signed 9/24 1944

G20968

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G20968 ✓ 927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Martin Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna M. Bowman

3 (b) If veteran, name war

3 (c) Social Security Account No. 579-10-1361

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1879

8. AGE: Years 65 | Months 5 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Saleslady

11. Industry or business

FATHER
12. Name George A. DeLaut
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary R. Batsdatis
15. Birthplace Baltimore, Md

16 (a) Informant Mary L. Kerber
(b) Address 3908 Northern Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Milton Ave & Gay St

18 (a) Funeral director Howard M. Blight Inc
(b) Address 4914 Belair Road

SEP 22 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22, 1944, at 4:25 A. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Co. Medical Examiner.
Date signed September 22, 1944.

Mariner ✓ G20969

BALTIMORE CITY HEALTH DEPARTMENT

G20969 CERTIFICATE OF DEATH 92 B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1644 No Bentlaw St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 33 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give name)
(d) Street No. 1644 No Bentlaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Mduncer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Jack

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER
12. Name Machman Lanier
13. Birthplace Russia
14. Maiden Name Shaya
15. Birthplace Russia

16 (a) Informant Jacob Manner
(b) Address 1641 N. Bentalwn St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-22-44 (month) (day) (year)
(c) Cemetery or crematory Woodvale
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 143 Baltic St.

19 SEP 22 1944 (Date rec'd by registrar) (b) Harrington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1944, at 8:47 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 16th 1942 to Sept 20 1944, and that I last saw h[illegible] alive on Sept 20 1944

	Duration
Immediate cause of death: arterio-sclerotic heart disease	1942
Due to: general arterio sclerosis	2
Due to: coronary sclerosis	
Other Conditions: Mitral Stenosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature N. A. Mulcahey M. D.
Address 2230 Eutaw Pl. Date signed 9/22/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 150

G20970 ✓ G20970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1648 Moreland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1648 Moreland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nathan Whitman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married.
6 (b) Name of husband or wife Sarah
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1869
8. AGE: Years 75 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Borach
13. Birthplace Russia

MOTHER
14. Maiden Name Rifka
15. Birthplace Russia

16 (a) Informant David Whitman
(b) Address

17 (a) Burial (b) Date thereof 9-22-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Wash. Blvd.
Location Wash. Blvd.

18 (a) Funeral director Jack Levin Inc
(b) Address 1437 E. Balto St

19 (a) SEP 22 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21-44 19 . at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 19 44 to 9/21/44 19 44.
and that I last saw him alive on 9/21/44 19 44

	Duration
Immediate cause of death Coronary occlusion	5 days
Due to arteriosclerosis	20 yrs
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Jack Cohen
Address 1806 Eutaw Place Date signed 9/22/44 M. D.

VS 180

G20971 | BALTIMORE CITY HEALTH DEPARTMENT | G20971

CERTIFICATE OF DEATH 74a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: Union Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Fon. Pk. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUIS ULMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Rose Ulman (nee Lotsman)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1873

8. AGE: Years	Months	Days	If less than one day
71			hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Contractor & Builder

11. Industry or business

FATHER
12. Name
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Rose Ulman
(b) Address 4109 Ulman Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jacob Levin Inc
(b) Address 1429 E. Balto. St

SEP 22 1944 (Date received by registrar) (b) Huntington Willard Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1944, at 10:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944, to 9/4 1944, and that I last saw h[illegible] alive on 9/21 1944.

Immediate cause of death	Duration
Coronary thrombosis	2 hrs.
Due to	
Due to	
Other Conditions Chronic hypertension Cancer of prostate (Include pregnancy within 3 months of death)	Chronic

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Marks M. D.
Address Robert Marks Union Hospital Date signed 9/22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G20972 (Registered No.)

G20972

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Do not use abbreviations. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert Street
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore #12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 724 McCabe Ave - Balto #12
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Wilton L. Davidson Sr.

3 (b) If veteran, name war: Vera Cruz
3 (c) Social Security Account No. 212-07-2975

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Theresa Davidson (Wife)
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 5/26/1894

8. AGE: Years	Months	Days	If less than one day
50	3	26	######## min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Overstage Jos C.
11. Industry or business Asst. Supt.

FATHER
12. Name Robert Davidson
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Dierckins (Dirschnider)
15. Birthplace Maryland.

16 (a) Informant Theresa Davidson (Wife)
(b) Address 724 McCabe Avenue

17 (a) Burial (b) Date thereof Sept. 23, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Ave., Balto; Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) SEP 22 1944 (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21 1944 at 6:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/22 1944, to 9/21 1944.
and that I last saw him alive on 9/20 1944.

Immediate cause of death	Duration
Cardio Resp. Failure	
Due to Pulmonary Evacuation and debility	
Due to Sarcoma with metastases	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Malignancy with Metastases

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Jane Jolley M. D.
Address Mercy Hosp. Date signed 9/21/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G20973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G20973 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Briscoe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Briscoe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward W. Moore

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Minnie Moore
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Nov 17, 1878

8. AGE: Years 65 | Months 10 | Days 3 | If less than one day hr. min.

9. Birthplace Somerset Co, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business retired

FATHER
12. Name John Moore
13. Birthplace Delaware

MOTHER
14. Maiden Name Frazier Gaskins
15. Birthplace Virginia

16 (a) Informant Mrs Minnie Moore
(b) Address 1006 Briscoe St.

17 (a) Burial (b) Date thereof 9/23/44 (month) (day) (year)
Burial, cremation, or removal
(c) Cemetery or crematory Mt Hebron Cemetery
Location Annapolis Blvd.

18 (a) Funeral director Earl L. Hess
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 22 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20th 1944 at 5.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/15/44 19 to 9/20/44 19, and that I last saw h i.m. alive on 9/20/44

Immediate cause of death: Cardiac failure — Duration
Due to Coronary artery disease
Due to Generalized arteriosclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isadore Strassburger M.D.
Address 601 N. Monroe Date signed 9/20/44

G20974

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G20974 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland D.O.H.
(b) Street address 544 St. Mary St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 544 St. Mary St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Satterfield

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-07-1088

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20, 1894

8. AGE: Years 50 | Months 3 | Days 2 0 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Hotel

FATHER
12. Name Not Known
13. Birthplace Not Known

MOTHER
14. Maiden Name Not Known
15. Birthplace Not Known

16 (a) Informant Mary Jackelfriend
(b) Address 709 W. Lafayette Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 22 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director John McThurgus
(b) Address 1700 Druid Hill Ave

19 (a) SEP 22 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h.d death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Charles L. Leibrich M.D. Medical Examiner.
Date signed 9/20/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20975

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G20975 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga Ave & Dukeland St.
(c) Hospital or institution West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town, give township)
(d) Street No. 530 N. Bloomingdale St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Anna Kreisinger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/1889

8. AGE: Years	Months	Days	If less than one day
54 yrs.	10	10	hr. min.

9. Birthplace Czechoslovakia (Town, county, and state)
10. Usual Occupation Nurse
11. Industry or business West.Balto.Gen.Hosp.

FATHER
12. Name Frank Kreisinger
13. Birthplace Czech.

MOTHER
14. Maiden Name Marie Teel
15. Birthplace Czech.

16 (a) Informant mother
(b) Address 530

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)
(c) Cemetery or [redacted] Oak Hill
Location Baltimore, Md.

18 (a) Funeral director C. E. Schimmnek
(b) Address 2601-03 E. Madison Street

19 (a) SEP 22 1944 Thurlington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1944, at 9:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/1 1944 to 9/19 1944, and that I last saw her alive on 9/19 1944.

Immediate cause of death	Duration
Terminal Bronchopneumonia	4 days
Due to Ca of Breast	
Due to Metastasis (Generalized)	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Irving J. Taylor
Address WBGH Date signed 9/19/44 (M. D.)

G20976

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 83a

G20976 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 601 Wise Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Irvin Disharoon

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Margaret (Murphy)
6 (c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1886

8. AGE: Years 57 | Months 11 | Days 26 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Boy tender
11. Industry or business Restaurant

FATHER
12. Name John S. Disharoon
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Margaret Disharoon
(b) Address 601 Wise Ave. Balto. 22

17 (a) Cremation (b) Date thereof Sept. 23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Sydney Rd.

18 (a) Funeral director John F. Connelly
(b) Address 4 Boston Ave. Curtis

19 (a) SEP 22 1944 (b) Signature by registrar Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1944, at 11 20 (AM) PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1944 to 9/20 1944 and that I last saw h/(m) alive on 9/20 1944.

Immediate cause of death: Cerebro-vascular accident — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at (AM) PM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. Carl Myers M. D.
Address Md. Gen. Hosp. Date signed 9/22/44

G20977

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G20977 Registered No.

CERTIFICATE OF DEATH 137a

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully supplied. The

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town [redacted] Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. 321 Hamberg Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. Kelver

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mary E. Kelver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years	Months	Days	If less than one day
63			hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Car repairman
11. Industry or business

MOTHER / FATHER
12. Name Henry Kelver
13. Birthplace Germany
14. Maiden Name Mary Frielein
15. Birthplace Md.

16 (a) Informant Mary Kelver
(b) Address 321 Hamberg Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Penna Rd & Bel Rd

18 (a) Funeral director John D Connelly
(b) Address 718 Eastern Ave. Essex 21

19 (a) SEP 22 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1944 to 9/21 1944, and that I last saw him alive on 9/21 1944.

Immediate cause of death	Duration
Uremia	
Due to Ureteral obstruction and anuria	
Due to P.O. Complications of Transurethral resection	
Other Conditions Peripheral vascular failure (Include pregnancy within 3 months of death)	
Date of operation 9-18-44	
Major findings of operation Prostatic hypertrophy	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edwin H. Stewart M.D.
Address Un. Hosp. Date signed 9/22/44

EDWIN H. STEWART - M.D.

325651 Brown

G20978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G20978 Registered No.

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W Va (b) County
(c) City or town Charlestown
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mabel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-6-84

8. AGE: Years 59 | Months 9 | Days 16 | If less than one day hr. min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual Occupation Insurance Agent.

11. Industry or business

FATHER 12. Name Gustav Brown
13. Birthplace Germany

MOTHER 14. Maiden Name Dora Mabbett
15. Birthplace Md.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 9-22-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Charlestown, W. Va.

18 (a) Funeral director Wm. J. Tilkens & Sons
(b) Address Balto., Md.

SEP 22 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 19 , at 9:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 12 1944 to Sept 22 1944 and that I last saw him alive on Sept 22 19 44

Immediate cause of death Pneumonia — Duration

following

Due to Pulmonary embolism

Due to Thrombophlebitis

Other Conditions Diabetes Mellitus Arteriosclerosis.
(Include pregnancy within 3 months of death)

Date of operation 9-13-44

Major findings of operation: Diabetes gangrene of extremities

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ross T. McLean M. D.
Address Johns Hopkins Date signed 9-22-44

G20979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

G20979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 904 Shells Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rudolph Garrett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-15-1927

8. AGE: Years	Months	Days	If less than one day
17	5	17	hr. min.

9. Birthplace Eastville, Va (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Montague Garrett
13. Birthplace Va

MOTHER
14. Maiden Name Ruby Widgeon
15. Birthplace Va

16 (a) Informant Mrs Ruby Widgeon
(b) Address 904 Shells Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (b)

SEP 23 1944 Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1944, at 4 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushing of head and body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-21-44 at 4:15 P.M.
(b) Where did injury occur? Waterview B&O R.R.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Passenger in auto - Struck by train.

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed Sept. 22, 1944.

SCS 151

G20980

JL - 83733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G20980

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 13 ds. 137

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 4018 Roland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lillian Mc Cauley

3 (b) If veteran, name war W

3 (c) Social Security Account No. NIRE

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1880

8. AGE: Years 63 | Months 0 9 | Days 29 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Y. McCauley

FATHER 13. Birthplace Md.

MOTHER 14. Maiden Name Madeline McIntosh

MOTHER 15. Birthplace Wash. D. C.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17. Burial (Burial, cremation, or removal) Date thereof 9/25/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cemetery Inc

Location Pikesville Md

18 (a) Funeral director Wilson Corse

(b) Address 12 N. St Paul St

19 (a) Date received by local registrar SEP 23 1944 (b) Signature and title of local registrar Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9- 1943 to 9-22 1944. and that I last saw h.C.R. alive on 9-22 1944.

Immediate cause of death Arteriosclerotic Cardio-Vascular disease

Duration
1 yr.

Due to

Due to

Other Conditions Generalized arterio-sclerosis

(Include pregnancy within 3 months of death)

Date of operation 9-29-43 & 2-7-44

Major findings of operation: Arteriosclerotic gangrene of extremities

of autopsy: Anasarca, ascites, pl. effusion

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Houck E. Belton

Address Balt. City Hosp. Date signed 9/27/44 W. D.

G20981 458964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E Registered No. G20981

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly. Every item of information should be carefully examined. Be

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Rocky Ridge
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Iolara Stambaugh

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-22-26

8. AGE: Years	Months	Days	If less than one day
18	3	0	hr. min.

9. Birthplace Rockbridge Md (town, county, and State)
10. Usual Occupation At School
11. Industry or business

FATHER
12. Name Harvey Stambaugh
13. Birthplace Md.

MOTHER
14. Maiden Name Maude Pryor
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25-1944 (month) (day) (year)
(c) Cemetery or crematory Rocky Ridge Cem
Location Rocky Ridge Md

18 (a) Funeral director M. L. Eyler Son
(b) Address Thurmont Md

19 SEP 23 1944 (Date received by registrar) Huntington Williamsport Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-22 1944, at 8.08 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-10 1944, to Sept-22 1944 and that I last saw h. alive on Sept 22 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of thyroid with metastases to pleura	3yrs 4 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Cerecer
Address J. Hopkins Hosp Date signed 9-22-44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20982

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G20982

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1707 CRYSTAL AVE
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1707 Crystal ave (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country

3 (a) FULL NAME DORA P. FETSCH.

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Nicholas J. Fetsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 2 - 1885 -

8. AGE: Years	Months	Days	If less than one day
59	2	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name August Prem
13. Birthplace Germany

MOTHER
14. Maiden Name Hannah Kleifle
15. Birthplace Maryland

16 (a) Informant Nicholas J. Fetsch
(b) Address 1707 Crystal Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-1944. (month) (day) (year)
(c) Cemetery or crematory Oakleaves
Location Eastern Ave

18 (a) Funeral director Kendall C. Humphreys
(b) Address 1601 N. Broadway

19 SEP 23 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21-44. 19 at 11 35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/22 1944 to 9/21 1944, and that I last saw h alive on 9/21 1944

Immediate cause of death Cardio-renal-
vascular disease — Duration 3 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature George A Barden M.D.
Address 1517 E Northern Date signed 9/23/44

VS 150

G20983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G20983 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 331 E. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 331 E. Lanvale St (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Bessie L. Belt

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Geo W. Belt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 28-1881

8. AGE: Years	Months	Days	If less than one day
63	0	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business Mattress Bergman

FATHER
12. Name Wm. C. Hewett
13. Birthplace Balt. Md

MOTHER
14. Maiden Name Jane E. Mc. Mainer
15. Birthplace Balto. Md

16 (a) Informant Miss Sue E. Hewett
(b) Address 331 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 23-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park. Location Baltimore Md

18 (a) Funeral director Geo L. Beyer Jr
(b) Address 1512 Hollins St

SEP 23 1944 (Date rec'd by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1942 to Sept 20 1944, and that I last saw him alive on Sept 20 1944.

Immediate cause of death: Arteriosclerosis of heart — Duration: 2 yrs
Due to:
Due to:
Other Conditions: Liver Metastasis — Duration: 6 Mos
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Lawrence M. D.
Address 753 W. Hoffman Date signed Sept 22 1944

VS 160

G20984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G20984

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 Hollins Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Adams

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Late Clara E. Adams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26-1879

8. AGE: Years	Months	Days	If less than one day
65	4	26	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Insurance agent.
11. Industry or business Life Insurance

FATHER
12. Name Charles W adams.
13. Birthplace Balto Md

MOTHER
14. Maiden Name Laura Saville.
15. Birthplace Md

16 (a) Informant Mrs. O. R. Rice.
(b) Address Wash. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Frederick Md

18 (a) Funeral director Geo. L. Beyard Jr
(b) Address N 12 Holliday St

19 (a) SEP 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1944 at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed September 22, 1944.

G20985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G20985
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Booth St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Booth St. (If rural give location)
(e) Citizen of foreign country? Booth (Yes or No)
If yes, name country

3 (a) FULL NAME. Elizabeth Washington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	Col'd	Married

6 (b) Name of husband or wife Samuel Washington 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1859

8. AGE: Years	Months	Days	If less than one day
85	2	22 20	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name William Morgan
13. Birthplace Snow Hill, Md.

MOTHER 14. Maiden Name Georgianna Hall-
15. Birthplace Annapolis, Md.

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 23 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1944 at 6.30 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1944 to Sept 20 1944 and that I last saw h-- alive on Sept 18 1944

Immediate cause of death Bronchial decompensation — Duration 7

Due to Hypertensive Arterio-sclerosis — ?

Due to —

Other Conditions Hemiplegia — ?

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. Wallace Sherwood M.D.
Address 701 N. Carey St. Date signed 9/22/44
Sherwood

G20986 — BALTIMORE CITY HEALTH DEPARTMENT — G20986 (Registered No.)

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 554 Presstman
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-3
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 554 Presstman (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel L. Counsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: W

6 (b) Name of husband or wife: William A.C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 30 1869

8. AGE: Years 74 | Months 9 | Days 20 | If less than one day ____ hr. ____ min.

9. Birthplace Essex Co. Va. (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Robert Rausom
13. Birthplace Va.

MOTHER 14. Maiden Name Polly Evans
15. Birthplace

16 (a) Informant Mrs. Ada Thomsen
(b) Address 1902 Potting Dr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mr. Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) SEP 22 1944 (Date filed by registrar) Registrar

Huntington Publishing Co., Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH (month) 9/20 (day) (year) 1944 (hour) 6:30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/13 1944 to 9/20 1944 and that I last saw h[illegible] alive on 9/20 1944.

Immediate cause of death: Arteriosclerosis
Due to: Senile Debility
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration: 2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature]
Address [illegible] Date signed 9/22/44 M. D.

G20987

461188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G20987

REGISTERED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Johns Hopkins Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 5

(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1204 Orange Court. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Baby Boy Hummer (Bernard Calvin Hummer Jr)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-19-44

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Bernard Hummer

13. Birthplace Va

MOTHER 14. Maiden Name Mary Huff

15. Birthplace Va

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 23/44 (month) (day) (year)

(c) Cemetery or crematory Lincoln Memorial Park

Location Berryville Va

18 (a) Funeral director Philip Henry Apple

(b) Address 2024 Eutaw St

19 (a) SEP 23 1944 (b) Huntington Williams 11 E

VS 180

MEDICAL CERTIFICATION

A

20. DATE OF DEATH Sept. 23 1944, at 4.50 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-21 1944, to Sept-23 1944, and that I last saw him alive on Sept-23 1944.

Immediate cause of death Cardiac failure

Due to congenital malformation of the heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Elizabeth Conrad M. D.

Address The Johns Hopkins Hosp Date signed 9-27-44

G20983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20983 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2603 Elsinor Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer S. Lambdin

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 214-20-2682

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Mrs Marietta Lambdin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4, 1877

8. AGE: Years 67 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Md. (Town, county, or state)

10. Usual Occupation Salesman Real Estate

11. Industry or business Brady Realty Co.

FATHER
12. Name Wm J. Lambdin
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Marshall
15. Birthplace Md

16 (a) Informant Marietta Lambdin
(b) Address wife

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

SEP 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1944, at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1944 to 9/22 1944 that I last saw him alive on 9/22 1944

Immediate cause of death: Cardiac Failure — Duration

Due to: Uremia

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S B Gray M.D.
Address Mercy Hosp Date signed 9/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G20989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G20989

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 301 E. 22nd St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 301 E. 22nd St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME WILLIAM H. COCKEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ida K.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1851

8. AGE: Years	Months	Days	If less than one day
93	0	33	23 hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business

FATHER
12. Name William H. Cockey
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Emma Oakley
15. Birthplace Balto. Co., Md.

16 (a) Informant Mrs. Ida K. Cockey
(b) Address 301 E. 22nd St.

17 (a) Burial (b) Date thereof 9/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 9/23/44 (b) .....
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Made 19 44 to 9/22 19 44, and that I last saw h alive on 8/31 19 44.

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Arteriosclerosis	6 mos
Due to Generalized Arteriosclerosis	10 Yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Thomas J. White M. D.
Address 522 E. 22nd St. Date signed 9/24/44

Hunting for William H. Cockey, M.D.

G20990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43

G20990 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Unit ✓
(b) Street address 33rd + Calvert Sts
(c) Hospital or institution:
Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2629 Miles Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gloria Ann Lanier

3 (b) If veteran, name war: **

3 (c) Social Security Account No.: --

4. Sex: FEM

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 mos. 8/21/44

8. AGE: Years | Months: 1 | Days: 0 | If less than one day: hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name John F Lanier
13. Birthplace Alabama

MOTHER
14. Maiden Name Clara Wadd?
15. Birthplace Virginia

16 (a) Informant Mr. John F. Lanier
(b) Address 2629 Miles Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)
SEP 23 1944
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar
SEP 23 1944 Huntington Hillcrest, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1944, at 7 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 19__, to Sept 21 1944 and that I last saw her alive on Sept 21 19 44.

Immediate cause of death Cardio respiratory failure — Duration 2 hrs

Due to Anemia — Duration 2 yrs

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W L Dunnell M. D.
Address Un. Mem. Hosp Date signed 9/25/44

G20991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20991
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. & John Street
(c) Hospital or institution: Hospital for Women of Maryland 12-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore-10 (If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W. University Pkway (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Armanda Nolting

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm G. Nolting
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) October 2 1868

8. AGE: Years	Months	Days	If less than one day
75	11	20	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name Joseph Bonn
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Fannie Kemp
15. Birthplace Baltimore

16 (a) Informant Miss Frances Nolting
(b) Address 100 W. Univ. Pkwy, Balto. 10

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) SEP 23 1944 (b) Registrar
(Date received by Registrar) Huntington Willard, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1944, at 4:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1944 to Sept. 22 1944 and that I last saw her alive on Sept. 22 1944

Immediate cause of death	Duration
Respiratory failure	1 min.
Due to Cardiac failure	3 mos.
Due to Hypertensive heart disease	10 years
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Mayone Levisohn M. D.
Address Hosp for Women of Md Date signed 9/22/44

G20992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G20992 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) ? 12 3
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 2806 E Calvert Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George ERNEST Kraft

3 (b) If veteran, name war NONE

3 (c) Social Security Account No. 213-03-6150

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Marcelline R. Kraft

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) May 5-1878

8. AGE: Years 66 | Months 4 | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation Book Salesman

11. Industry or business

FATHER
12. Name Geo. Coleman Kraft
13. Birthplace Balto.-Md.

MOTHER
14. Maiden Name Alice Binnix
15. Birthplace Maryland.

16 (a) Informant Mrs. Marcelline R. Kraft (wife-Divorced)
(b) Address 3321 Winterbourne Road-City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Greenmount Ave & Oliver St.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 100 W. NORTH AVENUE

19 (a) SEP 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1944, at 8:30 A. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed Sept. 22 1944

VS 161

G20993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

G20993 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2726 Ashland ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-23
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2726 Ashland ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F. Behrns
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	M

6 (b) Name of husband or wife Clara
6 (c) If alive, give age 29 years

7. Birth date of deceased (mo., day, yr.) Nov 28-1913

8. AGE: Years	Months	Days	If less than one day
30	9	23	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Martin Aircraft Co

FATHER
12. Name George. Behrns
13. Birthplace Balto.

MOTHER
14. Maiden Name Marguerite Mueller
15. Birthplace Balto.

16 (a) Informant Clara M. Behrns
(b) Address 2726 Ashland ave

17 (a) Balto. (Burial, cremation, or removal) (b) Date thereof Sept 13-44 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto.

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

SEP 9 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 11 1944, at 1:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 29 1944 to Sept 11 1944 and that I last saw him alive on Sept. 2d 1944.

Immediate cause of death Melanosarcoma of scalp (1y) — Duration 7 yrs
Due to Metastasis generalized
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation Oct. 1943
Major findings of operation:
Was autopsy?

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George D Lyons M. D.
Address 13 W Read St. Balto Md Date signed 9/12/44

(over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G20994 BALTIMORE CITY HEALTH DEPARTMENT G20994

CERTIFICATE OF DEATH 1600

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs 55 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 119 E. 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Benjamin Potter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/21/44

8. AGE: Years	Months	Days	If less than one day
			19 hr. 55 min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ben Potter
13. Birthplace Pittsburg, Pa

MOTHER
14. Maiden Name Alice Pickle
15. Birthplace Roanoke, Va

16 (a) Informant Alice Potter
(b) Address 119 E. 25th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Woodland Pk
Location Baltimore, Md

18 (a) Funeral director Harvard L. Young
(b) Address 21 W. 25th St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22nd 1944 at 1:55 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1944 to 9/22 1944, and that I last saw h[illegible] alive on 9/22 1944

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Birth -	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Brown M.D.
Address 708 Medical Arts Bldg Date signed 9/23/44

VS 150

G20995 BALTIMORE CITY HEALTH DEPARTMENT G20995

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2400 Harrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-0
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2400 Harrison Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jennie M. McSloraine
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Joseph V. McSloraine
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 4/1866
8. AGE: Years 77 Months 9 Days 19 If less than one day hr. min.
9. Birthplace Phila Pa. (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Thomas Farrell
13. Birthplace Ireland
MOTHER 14. Maiden Name Catherine Farrell
15. Birthplace Mohrsville Pa.
16 (a) Informant Annette M. Lloyd
(b) Address 2400 Harrison Blvd
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27/1944 (month) (day) (year)
(c) Cemetery or crematory Westminster
Location Phila Pa.
18 (a) Funeral director Harry R. Amacost
(b) Address 4204 Ridgewood Ave
19 (a) (b) Huntington Williams
SEP 25 1944
VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1944, at 1205 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to 9/23 1944 and that I last saw h alive on 19
Immediate cause of death Cerebral hemorrhage — Duration 1 day
Due to
Due to
Other Conditions Arteriosclerosis — ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Damian P. Magra M. D.
Address 336 Fredrick Ave Signed 9/24/44

G20996

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G20996 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street Residence Green Spring
(c) Hospital or institution: Levindale 2715
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Schiff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband, wife Amelia S. Schiff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1854

8. AGE: Years	Months	Days	If less than one day
90	5	9	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name — Schiff
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Sol M. Berman
(b) Address 3610 Clarinth Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/24/44 (month) (day) (year)
(c) Cemetery Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director David Sonneborn & Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 23 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-21 1944 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-16 1944 to 9-21 1944 and that I last saw h[illegible] alive on 9-21 1944

Immediate cause of death: Chr. card. vascular disease.
Arterio sclerosis, Hypertension.

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Edmund Irwin M. D.
Address Levindale Date signed 9/21/44

G20997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G20997
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1137 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1137 N. Gilmor St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME RAYMOND MCKINLEY G07459

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/22/44

8. AGE: Years | Months 1 | Days | If less than one day hr. min.

9. Birthplace Baltimore / Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John McKinley
13. Birthplace N. C.

MOTHER
14. Maiden Name Gertrude Walker
15. Birthplace Va.

16 (a) Informant John McKinley
(b) Address 1137 N. Gilmor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co. Md

18 (a) Funeral director Geo Halgreen
(b) Address 927 N Mount St

19 (a) (Date received by Registrar) SEP 23 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1944, at 6 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia, Lobular
Primary
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D. (or Medical Examiner.)
Date signed 9-23-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BIND

G20998

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G20998

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2434 Etting St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2434 Etting St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James W. Harvey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Cora Harveyson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/16/1888

8. AGE: Years 56 | Months 6 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation No occupation
11. Industry or business

FATHER
12. Name James Harvey, Sr.
13. Birthplace Maryland

MOTHER
14. Maiden Name Priscella Johnson
15. Birthplace Maryland

16 (a) Informant Cora Harvey
(b) Address 706 Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Gibertas
Location Md

18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Preston St

19 (a) SEP 23 1944 (Date rec'd by registrar) (b) Hunter & for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1944, at 1 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed Sept 22 1944

VS 151

MARGIN RESERVED FOR BINDING. Every item of information should be carefully written. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

G20999

Maurice L. Mason

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

Registered No. G20999

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Canton (If outside city or town limits, write RURAL and give town)
(d) Street No. 53 Seneca Canal (If no No., give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Maurice L. Mason

3 (b) If veteran, name war —

3 (c) Social Security Account No. 215-07-0242

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Married

6 (b) Name of husband or wife Helen H. Mason
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1, 1905

8. AGE: Years	Months	Days	If less than one day
36	0	27	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Crown Cork & Seal

MOTHER / FATHER
12. Name Edward F. Mason
13. Birthplace Maryland
14. Maiden Name Lola O. Shipley
15. Birthplace Maryland

16 (a) Informant Mrs. Elene Cassell
(b) Address 8196 Dundalk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25-1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) Date 9-23-1944 (b) Registrar Livingston Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1944, at 12 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1944 to 9-22 1944, and that I last saw h[illegible] alive on 9-22 1944.

Immediate cause of death	Duration
Acute hemorrhagic pancreatitis	5 days
Due to Common duct stone	6 days
Due to	
Other Conditions Paralytic ileus, Retroperitoneal hemorrhage (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Pancreatitis - Common duct stone

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isabella Hansson M. D.
Address Church Home & Hosp. Date signed 9-22-44

21000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. 62,000

PLEASE WRITE PLAINLY, with unfading ink. Use typewriter if possible. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 337 N Calvert St.
(c) Hospital or institution: Union Mem. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 26 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas William Lyon Thompson
3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife Emma
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 31, 1870

8. AGE: Years	Months	Days	If less than one day
73	11	1	0 hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Dorsey Thompson
13. Birthplace Maryland

MOTHER
14. Maiden Name Ruby Lyon
15. Birthplace Maryland

16 (a) Informant Mrs. Thomas Lyon
(b) Address Some address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 25, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Johns Cem.
Location Ellicott City, Md.

18 (a) Funeral director Easton Home
(b) Address Ellicott City, Md.

19 (a) (b) Registrar Huntington Williams, M.D.

SEP 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22- 1944 at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 27, 1944 to Sept 22 1944 and that I last saw h[illegible] alive on Sept 21, 1944

Immediate cause of death	Duration
Cong. heart failure & hypostatic pneumonia	3 days
Due to Fr. femur, rt.	
Due to accident	
Other conditions Arteriosclerotic heart dis.	

(Include pregnancy within 3 months of death)
Date of operation 9-12-44
Major findings of operation: Fr. neck of femur, rt.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: N-2
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-12-44 at [illegible] M.
(c) Where did injury occur? Union Mem. Hosp. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Hospital (Specify type of place) While at work? No
(e) Means of injury Fell in bed

23. Signature W. L. Wollenweber M.D.
Address Union Mem. Hosp. Date signed 9/23/44

W. L. Wollenweber MD Cor Lombard & Eutaw

G21001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

Registered No. G21001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct and is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 420 E Lafayette Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland L. Pence

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1944

8. AGE: Years — Months 3 4 Days 24 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Agnita Pence
15. Birthplace Huntington W. Va

16 (a) Informant Roy L. Bundy
(b) Address 1420 E Lafayette Ave

17 (a) Burial, cremation or removal (b) Date thereof 9/23/44 (month) (day) (year)
(c) Cemetery or crematory Huntington
Location Huntington W. Va

SEP 24 1944

18 (a) Funeral director Milburn Lodge
(b) Address 1217 E Fort St

SEP 24 1944 (Date received by Registrar) Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 19 , at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Status thymicus – lymphaticus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Graham M.D. Medical Examiner.
Date signed Sept 23 1944

VS 151

461103 G21002

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G21002 74a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 612 Water St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Blayman

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Ollie
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 5-30-84

8. AGE: Years	Months	Days	If less than one day
60	3	23	hr. min.

9. Birthplace W. Va (Town, county, and state)
10. Usual Occupation Home - Wife
11. Industry or business

FATHER
12. Name John Lucky
13. Birthplace W. Va.

MOTHER
14. Maiden Name
15. Birthplace Susan C. W. Va

16 (a) Informant Records JOHNS HOPKINS HOSPITAL
(b) Address

17 (a) Burial (b) Date thereof Sep. 23 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Elkins W. Va.

18 (a) Funeral director L. Heemann and Son
(b) Address 32 S. Broadway

19 (a) 9 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

✓

20. DATE OF DEATH Sept. 22 1944, at 10.19 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1944, to Sept 22 1944, and that I last saw h[illegible] alive on Sept. 22 1944

Immediate cause of death	Duration
Bronchopneumonia	1 day
Due to Hyperphoid Leukemia	10 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr.
Address Johns Hopkins Hospital Date signed 9/24/44

G21.003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21.003 ✓ 1190 Registered No.

Every item of information should be carefully answered. Write plainly, with UNFADING INK. Even if not applicable, write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hosp 2 6 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 LaRue Way
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Yvonne Marie Evans ✓

3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/9/43

8. AGE: Years	Months	Days	If less than one day
1	1	13	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Evans
13. Birthplace Ewell, Md.

MOTHER
14. Maiden Name Flossy Belle Marshall
15. Birthplace Ewell, Md.

16 (a) Informant father
(b) Address 1034 LaRue Way

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Oak Hill
Location Crisfield, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

(c) SEP 24 1944 (Date received by registrar) (d) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1944, at 11 25 M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Infantile Diarrhea

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 23 1944

G21004

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21004
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4407 Pall Mall Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4407 Pall Mall Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Kramer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Max
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-24-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Rd & Hamilton Ave

18 (a) Funeral director Jewish Funeral Home
(b) Address 1432 E. Baltimore St

19 (a) 9-24-1944 (date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22- 1944, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-22 1944 to 9-22 1944 and that I last saw h alive on 9-21 1944.

Immediate cause of death	Duration
Myocardial Infarction	
Due to Cardiovascular disease	yrs
Due to	
Other Conditions Diabetes Mellitus	yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature
Address 7904 Rush Rd Date signed 9/25/44 M.D.

G21.005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G21.005 95B Registered No.

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 Brunt
(c) Hospital or institution: Univ. Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1323 E. 35 St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kathryn Schnorrenberg

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, ~~married, widowed,~~ or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/1895

8. AGE: Years 46 | Months 2 | Days 8 | If less than one day hr. min.

9. Birthplace Steubenville, Ohio (Town, county, and state)

10. Usual Occupation School teacher

11. Industry or business

FATHER
12. Name John A. Schnorrenberg
13. Birthplace Pittsburgh

MOTHER
14. Maiden Name Melinda Hease
15. Birthplace Steubenville

16 (a) Informant Miss Margaret Schnorrenberg
(b) Address 1323 E. 35 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004-08 Orleans St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

SEP 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-20 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1944 to 9-20 1944, and that I last saw h[illegible] alive on 9-20 1944

	Duration
Immediate cause of death: Chronic heart failure	
due to: Pulmonary edema	24 hrs.
Due to: Rheumatic Heart Disease	20 yrs.
Due to:	
Other Conditions: Sub-acute Bact. Endocarditis	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Kemp M. D.
M.P. Address Univ. Hosp. Date signed 9-21

G21.006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G21.006 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1515 Bolton Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1515 Bolton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Bennett James

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Susan C. James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 1, 1857

8. AGE: Years	Months	Days	If less than one day
87	7	21	hr. min.

9. Birthplace Fall River, Massachusetts (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Inspector for Fire Underwriters Ass'n

FATHER
12. Name John James
13. Birthplace Virginia

MOTHER
14. Maiden Name Sarah Kenny
15. Birthplace Canton, Massachusetts

16 (a) Informant V. Marguerite James
(b) Address 1515 Bolton Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Henry W. Jenkins & Sons Co. Inc.
(b) Address McCulloh & Orchard Streets

19 (a) SEP 24 1944 (Date received by registrar) (b) Registrar Wilhelmina Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1944, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 28. 1937 to Sept. 22 1944 and that I last saw h[illegible] alive on Sept. 22 1944

Immediate cause of death	Duration
Cardiac decompensation	5 Mos.
Due to Chronic Bronchitis, Hist	20 yrs
Due to Chronic Myocarditis.	4 yrs
Other Conditions Arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Ward Wisner M. D.
Address 1125 Mercantile Bldg Date signed 9/25/44

J. Ward Wisner

G21007

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 477

Registered No. G21007

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 Ryan
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 921 Ryan St.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME John J Stedding

3 (b) If veteran, name war —
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife (Nee Wagner) Sarah L. Stedding
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1883

8. AGE: Years	Months	Days	If less than one day
60	10	4	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired City Employee
11. Industry or business —

FATHER
12. Name Henry Stedding
13. Birthplace ?

MOTHER
14. Maiden Name Elizabeth (?)
15. Birthplace ?

16 (a) Informant Sarah L. Stedding (wife)
(b) Address 921 Ryan St. (23)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25, 1944 (Month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Balto., Md.

18 (a) Funeral director C. Howard Evans
(b) Address 400 S. Charles St.

19 (a) 24 1944 (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21, 1944 at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 1944, to 9/21 1944, and that I last saw him alive on 9/21 1944

Immediate cause of death Carcinoma of Lung — Duration 1 year
Due to —
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work?
(e) Means of injury —

23. Signature Chas A Asher M. D.
Address 2145-W Balto St Date signed 9/23/44

VS 150

G21008

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G21008 97

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~2416 Montebello Terrace~~
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2416 Montebello Ter. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Lulalia Calloway Fortune

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John W. Sr.

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1880

8. AGE: Years 63 | Months 10 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Andrew J. Ryd

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Annie C. Credit

15. Birthplace Balto. Md.

16 (a) Informant Bernice Calloway Monroe

(b) Address 2416 Montebello Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 24, 1944 (month) (day) (year)

(c) Cemetery or crematory

Location Philadelphia, Pa.

18 (a) Funeral director Mrs. Fred H. Holland

(b) Address 1691 Druid Hill Ave. Baltimore, Md.

19 (a) SEP 25 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1944 at 2:04 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 30 1944 to Sept 23 1944 and that I last saw h[illegible] alive on Sept 23 1944.

Immediate cause of death	Duration
Cerebral arteriosclerosis	?
Malignant Hypertension	?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Bernard Harris M. D.

Address 1207 N Carrollton Date signed Sept 24, 44

G21009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rockwood & Wrenn
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Washington
(c) City or town Hagerstown (If outside city or town limits, write RURAL and give town)
(d) Street No. West Franklin St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Rumbaugh

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Catherine Rumbaugh
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years	Months	Days	If less than one day
30			hr. min.

9. Birthplace Frenchville Md (Town, county, and state)
10. Usual Occupation Tobacco
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Mrs. Henry Rumbaugh
(b) Address Hagerstown Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory Blooming Rose
Location Friendsville Md.

18 (a) Funeral director H. K. Hoffman
(b) Address Hagerstown Md.

19 SEP 25 1944 (Date rec'd by registrar) Huntington Williams Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1944 to 9-23 1944, and that I last saw h.im alive on 9-23 1944

Immediate cause of death Brain abscess

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Brain abscess

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Rinehart M. D.
Address Univ. Hosp. Date signed 9-24-44

G21010 Miaciech

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G21010

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 S Bond St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Joseph Miaciech

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-16-2324

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Dominica

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 42 (A) | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Jan Maciech
13. Birthplace Poland

MOTHER 14. Maiden Name Anny Yaslowska
15. Birthplace Poland

16 (a) Informant Dominica Miaciech
(b) Address 710 Bond St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23 1944 (month) (day) (year)

(c) Cemetery or crematory Laurel Hill Memory Park
Location Baltimore Co Md

18 (a) Funeral director James J Brzezynski
(b) Address 1946 Eastern Ave Rd

SEP 23 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 1944; at 2:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/17 1944 to 9/21 1944, and that I last saw h.. alive on 9/21 1944

Immediate cause of death Uraemia — Duration

Due to Generalized Carcinomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/18/44

Major findings of operation: Generalized Carcinomatosis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. E. Wallace M. D.

Address 1900 N. Caroline St Date signed 9/23/44

G21011

X4-89831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G21011

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs., 33 min

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1025 E. Madison St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Girl Brown (Anna Mae)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 1944

8. AGE: Years | Months | Days | If less than one day: 8 hr. 33 min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Sherman Brown

FATHER — 13. Birthplace Maryland

MOTHER — 14. Maiden Name Anna Mae Anderson

MOTHER — 15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-21-44 (month) (day) (year)

(c) Cemetery or crematory Baltimore City Hospitals Location 4940 Eastern Ave.

18 (a) Funeral director

(b) Address

19 (a) SEP 25 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-17 1944, at 4:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1944, to 9-17 1944, and that I last saw h. alive on 9-17 1944.

Immediate cause of death: CONGENITAL ATELECTASIS — Duration 8½ hrs.

Due to

Due to

Other Conditions prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. B. Penny, Jr. M.D. M. D.

Address Balto City Hosp Date signed 9/29/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21012

T.G.P.-89617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G21012

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 hours-35 minutes
(e) Length of stay in Baltimore (yrs., mos., or days) 19 hours-35 minutes

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 1008 Pennsylvania Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1944

8. AGE: Years | Months | Days | If less than one day: 19 hr. 35 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Monroe Banks
13. Birthplace ?

MOTHER
14. Maiden Name Mary Smith
15. Birthplace North Carolina

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremated (Burial, cremation, or removal) (b) Date thereof 9-21-44 3:30 PM (month) (day) (year)
(c) Cemetery or crematory Baltimore City Hospitals
Location 1940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 (Date received by Registrar) SEP 25 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1944, at 5:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944, to 9/2 1944, and that I last saw him alive on 9/2 1944.

Immediate cause of death	Duration
Anoxia	
Due to Congenital Atelectasis	1 day
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: None - Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. B. Runyon, Jr., M. D. M. D.
Address Balto City Hosp Date signed 9/9/44

C21013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. C21013

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Raynor & Oakeland
(c) Hospital or institution:
West Baltimore Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4003 Belvedere
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Holland

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 215-01-8063

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Ona Holland

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Mar. 29, 1892

8. AGE: Years	Months	Days	If less than one day
52	5	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Bar Tender

11. Industry or business

FATHER
12. Name James Holland
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Emery
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Inez Holland
(b) Address 4003 Belvedere Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Baltimore Highways

18 (a) Funeral director Fred. L. Hammerman
(b) Address 1316 N. Charles St.

SEP 25 1944
(Date rec'd by registrar)

Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 1944 at 10.15 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Diabetes Mellitus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Joseph B. McNally M.D.
Medical Examiner.

Date signed 9/21/44

G2.1014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

G2.1014 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore - 3 (If outside city or town limits, write RURAL and give town)
(d) Street No. 404 E. Preston St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marie Baker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Howard C. Baker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/24/1899

8. AGE: Years 45 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Sewing

11. Industry or business

FATHER 12. Name Thomas F. Golden Jenney
13. Birthplace Baltimore

MOTHER 14. Maiden Name Mary A. Curtis
15. Birthplace Baltimore

16 (a) Informant Howard C. Baker
(b) Address 122 Collins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 SEP 25 1944 (Date rec'd by registrar) (b) Huntington for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1944 at 7:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/21 1944 to 9/22 1944, and that I last saw her alive on 9/22 1944.

Immediate cause of death: Card. Failure — Duration

Due to: Uremia

Due to: Chron. Glom. Nephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify kind of place)
(e) Means of injury

23. Signature H. M. M. Crosby
Address Mercy Hospital Date signed 9/22

VS 150

G21015

BALTIMORE CITY HEALTH DEPARTMENT X V 461

CERTIFICATE OF DEATH

Registered No. G21015

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 605 Chapel Gate Lane
(c) Hospital or institution: Helena's Private Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Prince George
(c) City or town Riverdale
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian S Gartrell

3 (b) If veteran, name war — 3 (c) Social Security Account No. None

4. Sex Female — 5. Color or race White — 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Nov 16

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 60 — Months — Days — If less than one day hr. min.

9. Birthplace Montgomery Co Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wilbond A Gartrell
13. Birthplace Md

MOTHER
14. Maiden Name Alice Mary Waters
15. Birthplace Md

16 (a) Informant Benjamin B Nicols
(b) Address 2608 Mt Olivet Ave

17. (a) Burial (b) Date thereof 9/25/44
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Pine Grove
Location Mt Airy Md

18 (a) Funeral director Wilbond Lee Dove
(b) Address 1217 Park Ave

19. SEP 25 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1944 to 9/23 1944 and that I last saw h[illegible] alive on 9/23 1944

Immediate cause of death Carcinoma of Rectum — Duration 1 yr.

Due to

Due to

Other Conditions Carcinomatosis. — ?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Barbara P Clay M.D.
Address 326 Hillsdale Rd Date signed 9/27/44

VS 150

G21016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G21016

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 435 E. 22nd St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 435 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa G. Sunman
3 (b) If veteran, name war
3 (c) Social Security Account No.
4 Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1875
8. AGE: Years 69 Months Days If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business
FATHER 12. Name John Sunman
13. Birthplace Washington D C.
MOTHER 14. Maiden Name Lydia Sunman
15. Birthplace Baltimore
16 (a) Informant Miss L Sunman
(b) Address 435 E 22nd St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location
18 (a) Funeral director Maggie Wedefeld
(b) Address 501 E 22nd St.
SEP 25 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/1944, at 5:45 M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/21/1944, to 9/21/1944, and that I last saw h alive on 9/21/1944.

Immediate cause of death	Duration
Acute Congestive Heart failure	2 hours
Due to Myocarditis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Thomas F White
Address 532 E 22nd St. Date signed 9/23/44 M. D.

G21017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

G21017 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 Rochester Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 Rochester Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE LOVINIA NIEMILLER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: John C. Niemiller
6 (c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1880

8. AGE: Years: 64 | Months: 8 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: John Pulley
13. Birthplace: unknown

MOTHER
14. Maiden Name: Mary Betz
15. Birthplace: unknown

16 (a) Informant: Mr. John C. Niemiller
(b) Address: 115 Rochester Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-25-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 SEP 25 1944 (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION A.M.

20. DATE OF DEATH Sept. 22 1944, at 4.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 13 1944, to Sept 22 1944, and that I last saw h[illegible] alive on Sept 21 1944

Immediate cause of death: Cerebral Hemorrhage - Duration: 9/19/44
Arterial Hypertension + Sclerosis - 9/13/44 -
Due to
Due to
Other Conditions Chronic Myocarditis + Chronic Nephritis - 1 year
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: —
(a) Accident, suicide, or homicide
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —

23. Signature Lewis N. Kenwood M. D.
Address 722 N. Kenwood Date signed sept 24/44

G21018

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G21018

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood + Greene
(c) Hospital or institution: Univ. Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mo
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. - 16 (If outside city or town limits, write RURAL and give town)
(d) Street No. 2611 Garrison Blvd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lida J. Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Printing Salesman

11. Industry or business Printing

MOTHER / FATHER
12. Name Charles J. Taylor
13. Birthplace Maryland
14. Maiden Name Alvina Inslan
15. Birthplace Maryland

16 (a) Informant Hosp. administrator
(b) Address Univ. Redwood St

17 (a) Burial (b) Date thereof Sept 25 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Dolfield Ave.

18 (a) Funeral director John D. Mitchell & Son
(b) Address 1814 Eutaw Place

19 (a) SEP 25 1944 (b) Huntington, Wilkinson, Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23/44 19 , at 10 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 19 44, to 9/23 19 44, and that I last saw h alive on 9/22 19 44.

Immediate cause of death: Cachexia

Due to: Carcinoma of Ascending Colon

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 9/23/44

Major findings of operation: Carcinoma of Colon

of autopsy Carcinoma of Colon

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Strobel M. D.
Address Univ. Hospital Date signed 9/25/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

Registered No. G21019

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4418 Marble Hall Road
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 9
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4418 Marble Hall Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Hollstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Annie Merryman

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) April 15, 1863

8. AGE: Years 81 | Months 5 | Days 8 | If less than one day ....hr. ....min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Retired - Pres. of

11. Industry or business Hollstein Transfer Co.

FATHER
12. Name John C. Hollstein
13. Birthplace Germany

MOTHER
14. Maiden Name Emma Harman
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Annie M. Hollstein
(b) Address 4418 Marble Hall Road

17 (a) Burial (b) Date thereof 9/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~Greenmount~~ Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1906 Eutaw Place

19 SEP 25 1944 Worthington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1944, at 8.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1932, to Sept 23 1944 and that I last saw h me alive on Sept 23 1944.

Immediate cause of death: Myocarditis — Duration: Years

Due to: Arteriosclerosis! — Years

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ....at ....M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Worthington Williams

23. Signature M. D.
Address 20 E. Preston St. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21020
313-182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 567

Registered No. G21020

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Johns Hopkins 725
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2da.
(e) Length of stay in Baltimore (yrs., mos., or days) 2da

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town HAVANA (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Calzada (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country CUBA

3 (a) FULL NAME Elena Salazar Mola

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Child

6 (b) Name of husband or wife

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 4-4-35

8. AGE: Years 9 | Months 5 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Cuba (Town, county and state or foreign country)

10. Usual Occupation student

11. Industry or business

FATHER
12. Name Lino Salazar
13. Birthplace Cuba

MOTHER
14. Maiden Name Isabel Mola
15. Birthplace Cuba

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/44 (month) (day) (year)

(c) Cemetery or crematory Havana
Location Cuba

18 (a) Funeral director John D. Mitchell & Sons
(b) Address 1940 Eutaw Place

19 (a) SEP 25 1944 (Date rec'd by registrar) (b) Burlington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1944 at 6 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1944 to Sept 24 1944 and that I last saw her alive on Sept 24 1944

Immediate cause of death Brain Tumor — Duration 3 Wks 2 yrs

Due to .....

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

Date of operation Sept 23, 1944

Major findings of operation: Brain Tumor benign

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature Hugo V. Ruzzo M. D.
Address Johns Hopkins Hosp Date signed 9-24-44

Occ

G21021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

100 B

G21021 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1950 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1950 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hester Patterson Spencer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) ~~Single~~, married, widowed, or ~~divorced~~

6 (b) Name of husband ~~or wife~~ Frederick C.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 2 - 1868

8. AGE: Years 76 | Months 2 | Days 21 | If less than one day hr. min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name William Mullikey
13. Birthplace Ireland.

MOTHER
14. Maiden Name Bella Storey
15. Birthplace Ireland.

16 (a) Informant Helen Connell
(b) Address 3422 Catonsville

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director George A. Farley
(b) Address Fulton Ave and Fayette St.

19 (a) 9-25-1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 200

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27-1944, at 11.10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 7-1944, to Sept 24-1944, and that I last saw her alive on September 27 1944.

Immediate cause of death: Obstruction of Heart. — Duration: 1 month

Due to: Phlebitis — 2 months

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester Roland, M. D.
Address 2532 Edmondson Ave Date signed 9-24-44

G21022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G21022

89643

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: 3
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Darlene Carey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1944

8. AGE: Years	Months	Days	If less than one day
	1	23	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

MOTHER / FATHER
12. Name Oscar
13. Birthplace Va.
14. Maiden Name Doris Johnson
15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Edmondson Ave.
18 (a) Funeral director Burdell & Riepel
(b) Address 312 S. Highland Ave.
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 1944, at 9:10 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 9-3-1944 to 9-23-1944, and that I last saw her alive on 9-23-1944.

Immediate cause of death — Duration
Respiratory failure — 20 days
Due to
Acute nutritional disturbance
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Just done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature B C H. E. L. Sampson M.D.
Address Date signed 9/23

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21023

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

G21023 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1641 Hartford Ave. (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth W Dulin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Michael Dulin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 78 | Months — | Days — | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Joseph Rathgaber

13. Birthplace Germany

MOTHER 14. Maiden Name Regina Keefer

15. Birthplace Germany

16 (a) Informant Mrs R Rosenstock

(b) Address 2844 Pelham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-1944 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director Mary W Wiedefeld

(b) Address 30 E. 23rd St.

19 (a) SEP 25 1944 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1944 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1944 to 9/22 1944, and that I last saw h... alive on 9/22 1944.

Immediate cause of death	Duration
Carcinomatosis	?
Due to Acidosis	?
Due to Dehydration	?
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor

Address WBGY Date signed 9/22/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(2) G21024 ✓ G21024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13/a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1236 Ashland Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) 28 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1236 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Miles

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married

6 (b) Name of husband or wife Willie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1899

8. AGE: Years	Months	Days	If less than one day
45	4	19	hr. min.

9. Birthplace Washington D.C. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Smith
13. Birthplace Washington D.C

MOTHER
14. Maiden Name Rosie Stevenson
15. Birthplace Richmond Va.

16 (a) Informant Rosie Cooper
(b) Address 1236 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25/44 (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetary
Location

18 (a) Funeral director Mgr. Robert A. Elliott Dept.
(b) Address 1217 N. Caroline St.

SEP 25 1944

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9. 21 1944 at 7.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Cerebral hemorrhage — Duration 8 hours
Due to Hypertensive cardiovascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Rayner Browne M.D.
Address 1500 E. Madison St. Date signed 9/25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JL - 89728 G21025 BALTIMORE CITY HEALTH DEPARTMENT ✓ G21025

CERTIFICATE OF DEATH 46 B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1300 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1902

8. AGE: Years 42 | Months 4 | Days 9 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ben Brown
13. Birthplace Maryland

MOTHER
14. Maiden Name Georgianna Dorsey
15. Birthplace Maryland

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory Waterbury
Location Waterbury, Md.

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Broadway Huntingtown Williams

19 (a) SEP 27 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24-44 19 , at 1.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9/44 to 9/24/44, and that I last saw him alive on 9/24/44

Immediate cause of death Carcinoma of stomach
Liver metastasis — Duration ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/23/44

Major findings of operation: Cancer

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham
Address Balto City Hosp. Date signed 9-24-44 M. D.

32843 G21026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G21026
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Brent st.
(If rural give location)
(e) Citizen of foreign country? .....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary Hicks Campbell

3 (b) If veteran, name war ..... 3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Black	

6 (b) Name of husband or wife Bonnie Campbell
6 (c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) 9-8-21

8. AGE: Years	Months	Days	If less than one day
23 22	-	14	..... hr. ..... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Ford Wood
13. Birthplace Va.

MOTHER
14. Maiden Name Miriah Young
15. Birthplace Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 9/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lilian, Va
Location .....

18 (a) Funeral director Rev. H. Kelson
(b) Address 303 Pleasantman St

19 SEP 23 1944 (b) .....
(Date received by registrar) Huntington Williams, M.D. Registrar

VS 288

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22- 1944, at 2 39 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-23- 1944 to 9-22 1944; and that I last saw her alive on 9-22 1944.

Immediate cause of death	Duration
Tuberculous meningetis	3 days
Due to miliary Tuberculosis	? 3 months
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Abraham Cencin M. D.
Address J. Hopkins Date signed 9-23-44

G21027

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 94a

Registered No. G21027

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1032 E. North ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1032 E. North Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Walter Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Marietta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6 1888

8. AGE: Years	Months	Days	If less than one day: hr. min.
56	6	16	

9. Birthplace Balto. Md. (town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Grain Corn Meal

FATHER — 12. Name Michael Smith
15. Birthplace Balto. Md.

MOTHER — 14. Maiden Name Mary Hess
15. Birthplace Balto. Md.

16 (a) Informant Marietta Smith
(b) Address 1032 E. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-44 (month) (day) (year)
(c) Cemetery or crematory Balto. Mem. Park
Location E. North Ave
18 (a) Funeral director John A. McGuirian
(b) Address 4101 Gwynnbrook Ave. Huntington for Williams, M.D.

SEP 25 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 – 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 1944 to Sept 22 1944.
and that I last saw h.... alive on Sept 22 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 hr.
Due to
Due to
Other Conditions Ht. Hernia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Lawrence L. Green M. D.
Address 1761 E North Ave Date signed 9/27/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21028

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓107

Registered No. G21028

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. Gen'l. Hosp. 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 E. 20th St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Wilbur C. Maulsby — Wilbur Carroll Maulsby

3 (b) If veteran, name war: Yes
3 (c) Social Security Account No. 212-07-6564

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Gertrude M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1892

8. AGE: Years 52 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Lithographer
11. Industry or business "

FATHER
12. Name Augustus C. Maulsby
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Ann R. Howard
15. Birthplace Balto. Md.

16 (a) Informant wife (Gertrude)
(b) Address 1116 E. 20th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/44 (month) (day) (year)
(c) Cemetery or crematory Wood Lawn
Location

18 (a) Funeral director H. W. E. Dipple's Sons
(b) Address 740 Hollins St. (Name of city or town)

SEP 25 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24/1944 at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22/1944, to 9/24/1944, and that I last saw him alive on 9/24/1944.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Bronchopneumonia.	
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. L. McCormack M. D.
Address Md. Gen Hosp Date signed 9-27-44

G21029 BALTIMORE CITY HEALTH DEPARTMENT G21029

CERTIFICATE OF DEATH 66B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Light Street
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 dys.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 dys.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5342 Wright
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Judith Diane Wilkinson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 6, '44

8. AGE: Years	Months	Days	If less than one day
		18	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business —

FATHER
12. Name Benjamin Wilkinson
13. Birthplace Dry Gull, Va.

MOTHER
14. Maiden Name Inez Trimal
15. Birthplace Camden, S.C.

16 (a) Informant Benjamin Wilkinson
(b) Address 5342 Wright Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippelt Sons
(b) Address Lan Gard & Ann Sts.

19 (a) Date received SEP 25 1944 (b) Registrar Huntington Williams

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1944, at 9:32 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19-44 1944 to 9-24 1944, and that I last saw h e c alive on 9-24 1944

Immediate cause of death	Duration
Cerebral Hemorrhage. Malnutrition	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles A. Marchand M. D.
Address 1913 Light St Date signed 9-24-44

G21030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G21030

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2118 N. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2118 N. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary E. Showalter

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Tracey I. Showalter
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1876

8. AGE: Years	Months	Days	If less than one day
68	7	20	hr. min.

9. Birthplace Harrisonburg, Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name D. E. McGraughlin
13. Birthplace Va.

MOTHER
14. Maiden Name Virginia Grey
15. Birthplace Va.

16 (a) Informant Miss Norma Showalter
(b) Address 2118 N. Balto. St.

17 (a) Burial (b) Date thereof 9/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodbine
Location Harrisonburg, Va.

18 (a) Funeral director F. B. Kyle Sons
(b) Address 1850 N. Baltimore St

SEP 25 1944 (b) Huntington Williams M.D.
(Date received) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1944, at 8:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1944 to 9/24 1944 and that I last saw her alive on 9/24 1944

	Duration
Immediate cause of death Pneumonia, Hypostatic.	3 days
Due to Myocardial degeneration.	?
Due to Arterio-Sclerosis - cerebral	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Neal E. Bogrod M. D.
Address 1905 W. Balto. St. Date signed 9/25/44

G21031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. G21031

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 N. Fayette Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James C. Post (James Carlton Post.)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 3. 1928

8. AGE: Years 16 | Months 8 | Days 21 | If less than one day ..... hr. ..... min.

9. Birthplace Coppen West Va. (Town, county, and state)

10. Usual Occupation School Boy.

11. Industry or business

FATHER
12. Name O. H. Post.
13. Birthplace Coppen West Va.

MOTHER
14. Maiden Name Estella Stoyler.
15. Birthplace Coppen. West Va.

16 (a) Informant O. A. Post.
(b) Address Coppen. West Va.

17 (a) Shipped. (Burial, cremation, or removal) (b) Date thereof 9. 25. 44 (month) (day) (year)
(c) Cemetery or crematory Gilmer Station WEST VA
Location West Va.

18 (a) Funeral director ROBERT BROOKS & SON
(b) Address 1338 Hollins Street.

19 (Date rec'd by Registrar) SEP 25 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24- 19 44 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-23-44 at 7:20 P.M. 19-2
(b) Where did injury occur? Strecker & Fayette Streets
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? ?
(d) Means of injury Struck by street car. Pedestrian

23. Signature Howard J. Rhudy M.D. Medical Examiner.
Date signed 9-24-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21032

Greenfield 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Pinkney Av
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits write RURAL and give town)
(d) Street No. 1010 Pinkney Av (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Greenfield

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race col | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1882

8. AGE: Years 62 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Matilda Cole
(b) Address 1016 N Pinkney Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26, 1944 (Month) (day) (year)
(c) Cemetery or crematory Mount Lion
Location Baltimore County

18 (a) Funeral director Joseph A. Simply
(b) Address 4040 N Mount street

19 (a) (Date of filing) 1944 (b) Huntington Williams M.D.

$8.25

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23- 1944 at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1944 to 9-23 1944, and that I last saw h alive on 9-23 1944.

Immediate cause of death: Chronic Ny nephritis — Duration: 6 mos
Due to cardiovascular Renal disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Jackson M.D.
Address 600 Washington Ave signed 9/24/44

G21033
86015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G21033
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days): 8 - 8
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 901 Fell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: Andrew Bockert

3 (b) If veteran, name war:
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Rose (D)
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 22, 1887

8. AGE: Years: 57 | Months: 0 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual Occupation:
11. Industry or business:

FATHER
12. Name: Frank Bockert
13. Birthplace: Md.

MOTHER
14. Maiden Name: Annie Dotterweich
15. Birthplace: Md.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: German Hill Road

18 (a) Funeral director: Lilly & Zahn
(b) Address: 403 S. Wolfe Street

19 SEP 25 1944 (Date rec'd by registrar) (c) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/25 1944, at 1:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/17 1944, to 9/25 1944, and that I last saw h. alive on 9/25 1944.

Immediate cause of death: Pulmonary Tuberculosis — Duration: 1

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Shea Holle M. D.
Address: Balt City Hosp Date signed 9/25/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1/313

Registered No. G21034

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST.JOSEPH HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 DAS
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N.STREEPER ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Sebastian C. Schlauch

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 219 03 4336

4. Sex: MALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: BARBARA SCHLAUCH

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): APR.24 1878

8. AGE: Years: 66 Months: 4 Days: 22 If less than one day: hr. min.

9. Birthplace: BALTIMORE MD. (Town, county, and state)

10. Usual Occupation: WATCHMAN At CANTON

11. Industry or business: RAIL ROAD

FATHER
12. Name: GEORGE SCHLAUCH
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: MARY COX
15. Birthplace: GERMANY

16 (a) Informant: BARBARA SCHLAUCH(WIFE)
(b) Address: 620 N.STREEPER ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: SEPT.25/44 (month) (day) (year)
(c) Cemetery or crematory: OAK HILL
Location: 1300 HORNERS LANE

18 (a) Funeral director: Lilly E. Jackson
(b) Address: 403 S.WOLFE ST.

19 (a) SEP 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 1944 at 6:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1944, to 9/22 1944, and that I last saw h.i.m. alive on 9/22 1944.

Immediate cause of death: Uremia — Duration:

Due to: Ch. Nephritis

Due to:

Other Conditions: Bleeding Sepsis Ulcer.
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. H. E. Wallace M. D.
Address 1400 N. Caroline St. Date signed 9/25/44

G21035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G21035

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Jo A Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3028 Remington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hoshall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	WIDOWER

6 (b) Name of husband or wife MAMIE HOSHALL
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) APRIL 1, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	22	hr. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual Occupation RETIRED OPERATER.
11. Industry or business BALTO TRANSIT CO.

FATHER
12. Name JOSEPH HOSHALL
13. Birthplace MARYLAND.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant RAYMOND HOSHALL
(b) Address 3416 KESWICK ROAD.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 27/44 (month) (day) (year)
(c) Cemetery or crematory WOODLAWN.
Location

18 (a) Funeral director Clarence R. Donovan
(b) Address 3615 Clarendon Ave
19 SEP 25 1944 (Date rec'd by registrar) (b) Huntingtown, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1944, at 8.20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to nature death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Nicholson M.D.
Medical Examiner.
Date signed 9/23/44.

VS 151

G21036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G21036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. 40th. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Cromwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower.

6 (b) Name of husband or wife Esa Cromwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5 1885

8. AGE: Years 59 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Street Cleaner

11. Industry or business Balto City.

FATHER
12. Name Wm Cromwell
13. Birthplace Md.

MOTHER
14. Maiden Name Fanney DeWeese
15. Birthplace Md

16 (a) Informant Clarence J. E. Cromwell
(b) Address 903 W. 40th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27 44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Taylor Ave.

18 (a) Funeral director Chenowith & Donovan
(b) Address 2615 W Chestnut Ave

19 SEP 25 1944 (Date received by registrar) Thurlington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24, 1944, at 2:35 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeier M.D.
Medical Examiner.
Date signed September 25, 1944.

VS 151

G21037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G21037

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3306 Harford Rd
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Emma Christina Rossing

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, (widowed), or divorced.

6 (b) Name of husband or wife Henry ch. Rossing

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec. 11, 1865

8. AGE: Years 78 | Months 9 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name George Fisher
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Miller
15. Birthplace Germany

16 (a) Informant Mrs. J. Milton Rossing
(b) Address 3306 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27/44 (month) (day) (year)

(c) Cemetery or crematory Bolton Hill
Location Baltimore

18 (a) Funeral director Philip Henry Sons
(b) Address 2044 Orleans St

19 (a) ____ (b) Huntington Williams, M.D.

SEP 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1944 at 9 15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1944 to 9-24 1944 and that I last saw her alive on 9-24 1944.

Immediate cause of death	Duration
Cardio-Resp. failure	
Due to Arterio-sclerotic Heart Disease	
Due to	
Other Conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Humpstone Jr. M. D.
Address 33 E. University Pkwy Date signed 9/24/44

G21038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1119a

Registered No. G21038

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hosp
(c) Hospital or institution 1800 N. Monument St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2206 Orleans St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Louise Yost

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Wh	S

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2, 1944

8. AGE: Years	Months	Days	If less than one day
	3	22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Daniel Yost
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Smith
15. Birthplace Baltimore

16 (a) Informant Mr Daniel Yost
(b) Address 2206 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26/44 (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem
Location Baltimore
18 (a) Funeral director Philip Sherwood Sons
(b) Address 2024 Orleans St
19 (a) (Date rec'd by local registrar) (b) Huntington Hill Registrar

SEP 25 1944 VS/156

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24/44 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23/19 44 to 9/23/19 44 and that I last saw him alive on 9/23/19 44

Immediate cause of death Circulatory collapse — Duration

Due to dehydration sudoris

Due to uncontrolled diarrhea

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Murray Werner M.D.
Address Sinai Hosp Date signed 9/24/44

G21039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G21039 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 - N. Carolina St.
(c) Hospital or institution: St. Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3415 Roselawn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lilly

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1944

8. AGE: Years	Months	Days	If less than one day
			11 hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name John R Lilly
13. Birthplace Chicago, Ill.

MOTHER
14. Maiden Name Lillian Hoelzle
15. Birthplace N. Y.

16 (a) Informant Charles Hoelzle
(b) Address 3415 Roselawn ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/25/44 (month) (day) (year)
(c) Cemetery or crematory Morehead Park
Location Taylor Ave Parkville

18 (a) Funeral director Howard M. Bright Jr.
(b) Address 4914 Belair Road

(a) (Registrar) (b) Huntington Williams M.D.

SEP 25 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1944 at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1944 to 9/24 1944 and that I last saw h[illegible] alive on 9/24 1944.

Immediate cause of death	Duration
Atelectasis	
Due to	
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. B. Ballena M.D.
Address St. Joseph's Hosp Date signed 9/24/44

G21040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G21040

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 822 Manigold St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL or name of town)
(d) Street No. 822 Manigold St,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Velivis

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known ?

8. AGE: Years	Months	Days	If less than one day
53 ?			hr. min.

9. Birthplace Lithuanian
(Town, county, and state)
10. Usual Occupation Tailor
11. Industry or business Clothing

FATHER
12. Name John Velivis
13. Birthplace Lithuanian

MOTHER
14. Maiden Name Anna ?
15. Birthplace Lithuanian

16 (a) Informant Mr. Velivis
(b) Address % 423 S.Paca St.,

17 (a) Burial (b) Date thereof Sept. 26, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart of Mary
Location German Hill Road

18 (a) Funeral director John A. Grabiancheck Jr
(b) Address 423 S.Paca St.,

19 (a) Date received by registrar SEP 25 1944 (b) Registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Sept. 23 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19 1944 to 9/23 1944
and that I last saw h alive on 9/23 1944

Immediate cause of death — Duration
(a) Acute Cardiac Failure — 12a
Due to (b) Coronary Disease — 2 Mos
Due to (c)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph G. Landcarty M.D.
Address 822 Manigold St. Date signed Sept 25 1944

G21041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G21041 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1912 W. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1912 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME H. Frederick Uhlenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	married

6 (b) Name of husband or wife Gertrude Conner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 27 1877

8. AGE: Years	Months	Days	If less than one day: hr.	min.
67	-	25		

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Chief Clerk
11. Industry or business Glass Works

FATHER
12. Name Herman H. Uhlenberg
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine M. Brookhagen
15. Birthplace Germany

16 (a) Informant Gertrude Uhlenberg
(b) Address 1912 W. Saratoga

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cathedral
Location Frederick Road

18 (a) Funeral director Frank V. Pipitone
(b) Address 2218 E. Baltimore St

SEP 25 1944 (Date received by registrar) (b) Huntington for Nicholas, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1944, to 9/22 1944, and that I last saw him alive on 9/22 1944.

Immediate cause of death	Duration
Acute Pulmonary Edema	1 day
Due to Pulmonary Heart Disease	2 yrs
Due to Emphysema	10 yrs
Other Conditions Arteriosclerosis	10 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. E. Roach M. D.
Address 3629 Edmondson Date signed 9/23/44

Thos. E. ROACH

VS 180

G21042

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G21042
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied if possible. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1722 Johnson
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) VA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1722 Johnson (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine F. MacDonald

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife James E. MacDonald | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 5/68

8. AGE: Years 76 | Months 8 | Days 18 | If less than one day hr. min.

9. Birthplace Prince Edward, Canada (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Hector Cantelo
15. Birthplace Canada

MOTHER 14. Maiden Name Margaret McFee
15. Birthplace Canada

16 (a) Informant Jas. E. MacDonald
(b) Address 1722 Johnson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 26/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Md

18 (a) Funeral director Flynn & Fleming
(b) Address 1422 Light St

17 (c) Filed SEP 25 1944 (Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1944, at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1944 to Sept 23 1944 and that I last saw her alive on Sept 23 1944.

	Duration
Immediate cause of death: Exhaustion	2 to
Due to: Arteriosclerosis	Indef
Due to:	
Other Conditions: (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. E. L. Campbell M. D.
Address 1644 Hanover St Date signed 9/26/44

G21043

G21043

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 92a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined. correct age is especially important. Physician please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 883 N. Patterson Park Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F. Leuisfeld

3 (b) If veteran, name war: Yes.

3 (c) Social Security Account No. None

4. Sex: Male. Color or race: White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife: Lena Leuisfeld

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1864

8. AGE: Years 80 | Months - | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant C. Louis Miller
(b) Address 2120 W. Fayette Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 27, 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3801 Frederick Ave

18 (a) Funeral director Charles F. Dill.
(b) Address 3109 Frederick Ave.

19 (a) (Date received by registrar) SEP 29 1944 (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 19 44, at 12:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Valvular Heart Disease. Mitral and Aortic Stenosis.

Due to

Other Conditions Fracture of Right Tibia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☒ cause of death, fill in the following:
(a) Date of injury 8-10-44 at 10:55 A M.
(b) Where did injury occur? Patterson Park Ave & Madison St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by Auto.

23. Signature Henry L. Wollenweber, M.D. Medical Examiner.
Date signed Sept. 25/1944.

G21044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21044 Registered No. 108

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Greene
(c) Hospital or ~~institution~~: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1903 N. Gilmington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Beall

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-01-3418

4. Sex M | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~

6 (b) Name of ~~husband~~ or wife Hannah

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19 1887

8. AGE: Years 57 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

MOTHER / FATHER
12. Name Hezekiah Beall
13. Birthplace Md
14. Maiden Name Marcelena Bell
15. Birthplace Md.

16 (a) Informant Hosp. records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/44 (month) (day) (year)
(c) Cemetery or crematory Balto.
Location Balto. Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address 1938 E. Lafayette Ave.

19 (a) Filed SEP 29 1944 (Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 19 44 at 10 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1944, to 9-23 1944
and that I last saw him alive on 9-23 19 44

Immediate cause of death Pneumonia — Duration

Due to —

Due to —

Other Conditions Cirrhosis of Liver
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pneumonia. Cirrhosis

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Shipley M. D.
Address Univ. of Md. Hosp. Date signed 9-24-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92E

G21045 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3725 Harmon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5207 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman S. Kirk

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-7897

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Mildred Hutchinson Kirk

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb. 18 1895

8. AGE: Years	Months	Days	If less than one day
49	7	6	hr. min.

9. Birthplace Baltimore Co. Md.
(Town, county, and state)

10. Usual Occupation Tool & Die Maker

11. Industry or business Edgewood Arsenal

FATHER
12. Name Wilfred Kirk
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Annie Wallace
15. Birthplace Baltimore Md.

16 (a) Informant Vera H. De Voe.
(b) Address 3725 Harmon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 25 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Balto Co. Md.

18 (a) Funeral director J. Willis Lawrence
(b) Address 4510 Liberty Heights Ave

19 (a) (Date rec'd by registrar) (b) Permit issued

SEP 25 1944

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24" 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1944, to Sept 24 1944, and that I last saw h[e] alive on Sept 23 1944.

Immediate cause of death Coronary Thrombosis

Duration 5 min

Due to Septicemia 16 days

Due to Endocarditis 10 years

Due to Syphilis 2 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos G Abbott

Address 4509 Liberty Hgts Ave Date signed 9/25/44

G21046

BALTIMORE CITY HEALTH DEPARTMENT X ✓

CERTIFICATE OF DEATH 45c

Registered No. G21046

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U.S.Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 10/23/43
(e) Length of stay in Baltimore (yrs., mos., or days) Since 10/23/43

2. USUAL RESIDENCE OF DECEASED:
(a) State NC (b) County
(c) City or town Elizabeth City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 915 Southern Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ROSS OWENS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1881

8. AGE: Years	Months	Days	If less than one day
63	8	1	hr. min.

9. Birthplace Dare County, N.C.
(Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Merchant Marine

FATHER
12. Name George W. Owens
13. Birthplace Dare County, N.C.

MOTHER
14. Maiden Name Ellen Stanley
15. Birthplace Dare County, N.C.

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 28-44 (month) (day) (year)
(c) Cemetery or crematory Hollywood
Location Elizabeth City, N. Carolina

18 (a) Funeral director E Haworth Arrgmts
(b) Address 3911 Liberty Heights Ave

19 (a) SEP 26 1944 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 25, 1944 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23, 1943 to Sept.25 1944 and that I last saw him alive on Sept.25, 1944

Immediate cause of death 1. Squamous cell carcinoma of mouth with metastasis to neck; 2. Marked ulceration and irradiation necrosis. floor of mouth & left submental region.

Duration: Appr. from 4/1941

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/16/43 & 1/26/44-
Major findings of operation: Osteomyelitis rt. mandible & Ulceration of rt. anterior floor of mouth
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Baltimore, Md. Date signed 9/25/44 M.D.

VS 150

MS-48704

G21047

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

✓ G21047 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. & John Street
(c) Hospital or institution Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 704 Hollen Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Hollen

3 (a) FULL NAME Baby Girl "B" Evans

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1944

8. AGE: Years 0 | Months 2 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business None

FATHER
12. Name Edward H. Evans jr.
13. Birthplace Virginia

MOTHER
14. Maiden Name Treva Mae Coffin
15. Birthplace Nebraska

16 (a) Informant Treva Mae Evans
(b) Address 704 Hollen Road

17 (a) ... (Burial, cremation, or removal) (b) Date thereof 9/22/44 (month) (day) (year)

(c) Cemetery or crematory Hospital
Location

18 (a) Funeral director
(b) Address

19 (a) SEP 26 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1944 at 9:00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to Sept. 20 1944 and that I last saw h[illegible] alive on Sept. 20 1944

Immediate cause of death	Duration
Respiratory failure	3 mins
Due to Congenital heart disease	2½ mos.
Due to	
Other Conditions Prematurity	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: Congenital heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury

23. Signature Maryone J. Lewcock M.D.
Address Hosp. for Women of Md. Date signed 9/25/44

G21048

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$2a

G21048 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 118 A. Eutaw St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4'
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 118 A Eutaw St
(If rural give location)
(e) Citizen of foreign country? [redacted] (Yes or No)
If yes, name country

3 (a) FULL NAME FERDINAND H. JACOBER.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of ~~husband~~ or wife: Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): APR 18 1855

8. AGE: Years 89 | Months 5 | Days 5 | If less than one day: hr. min.

9. Birthplace: Switzerland (town, county, and state)

10. Usual Occupation: Barber
11. Industry or business: Self

FATHER
12. Name: not known
13. Birthplace: Switzerland

MOTHER
14. Maiden Name: not known
15. Birthplace: Switzerland

16 (a) Informant: Mrs. D. Gerber
(b) Address: 118 E. Eutaw St 9/26

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Balto
Location: E. North Ave

18 (a) Funeral director: Geo. H. Kemsbach
(b) Address: 525 N. Lynchurst St

SEP 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-23 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6-15- 1944, to 9-23 1944, and that I last saw living on 9-23 -1944.

Immediate cause of death — Duration

Due to Cerebral Haemorrhage

Due to Arteriosclerosis

Other Conditions Old age

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert C. Blake M. D.
Address Med Arts Bldg Date signed

G21049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ G21049 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Caplis

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Dina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years	Months	Days	If less than one day
67			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Dina Caplis
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Bluefields Rd
18 (a) Funeral director Levy Bros Inc
(b) Address 1439 E. Balto St
19 (a) (Date rec'd by registrar) (b) Registrar

SEP 26 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1944 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/14 1944, to 9/25 1944 and that I last saw him alive on 9/25 1944.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to Hypertensive Cardio-Vascular Disease	
Due to Cardiac enlargement	
Other Conditions Decompensated	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor
Address WBGH Date signed 9/25/44

G21050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G21050
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Room Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 3 days
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 W University Pky.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Fannie Lincoln Lederer

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: Henry G. Lederer
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Nov 29 1864

8. AGE: Years	Months	Days	If less than one day
79	10	21	hr. min.

9. Birthplace: Baltimore
(Town, county, and state)
10. Usual Occupation: none
11. Industry or business: none

FATHER
12. Name: Geo. W. Richardson
13. Birthplace: Balto Md

MOTHER
14. Maiden Name: Julia Birmingham
15. Birthplace: Balto Md

16 (a) Informant: Mrs A Lederer (Son)
(b) Address: 5001 Emblaton.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sep 26 44 (month) (day) (year)
(c) Cemetery or crematory: Lyndelwood
Location: Fredk Rd. City.

18 (a) Funeral director: STEWART & MOWEN COMPANY
(b) Address: (W. F. WOODEN SUC.) 100 W. NORTH AVENUE
SEP 26 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1944, at 1 00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1944 to 9/23 1944, and that I last saw h.e.r alive on 9/23 1944

Immediate cause of death: Peritonitis — Duration: 3 days

Due to: Rupture of Gall Bladder — 3

Due to: Acute Cholecystitis & Cholelithiasis — 3

Other Conditions: Pancreatitis

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Biliary Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: James S. Shoaff M. D.
Address: U. Hosp. Redwood & Hwy Date signed 9/23/44

G21051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G21051

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene sts
(c) Hospital or institution:
University Hospital 21

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 14hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 777 W Pratt st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-18-44

8. AGE: Years	Months	Days	If less than one day
			14 hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Enfant

11. Industry or business

FATHER
12. Name Rudolf Williams
13. Birthplace

MOTHER
14. Maiden Name Thelma Thompsen
15. Birthplace

16 (a) Informant Thelma Williams
(b) Address 777 W. Pratt st

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 26 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-18 1944, at 9 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1944, to 9-18 1944, and that I last saw him alive on 9-18 1944.

Immediate cause of death prematurity 21bs 7oz

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William D. Ly M. D.
Address University Hospital Date signed 9-19-44

VS 150

2182

621052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

621052
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. + John Street
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town).
(d) Street No. 639 Aldershot Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy BRADLEY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1944

8. AGE: Years — Months — Days — If less than one day 23 hrs. 34 min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name William P. Bradley jr.
13. Birthplace Four Oaks, Penna.

MOTHER
14. Maiden Name Helen Louise Campney
15. Birthplace Du Bois, Penna.

16 (a) Informant Helen Louise Bradley
(b) Address Baltimore, Maryland

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 25 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 26 1944 (Date rec'd by registrar) (b) Hunter Jon Williams, M.D. Registrar

VS 1

2181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 19 44 at 8:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 19 44 to Sept. 22 19 44 and that I last saw h.. alive on Sept 22 19 44.

	Duration
Immediate cause of death: Respiratory failure	2 hrs.
Due to: Congenital heart disease	1 day
Due to:	
Other Conditions: Diaphragmatic hernia, left. Atelectasis (Include pregnancy within 3 months of death)	

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marjorie G. Lewinsohn M.D.
Address Women's Hospital Baltimore, Md. Date signed 9/22/44

G21053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G21053

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun Sts
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 208 N. Vincent St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel George Tumminello

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-17-44

8. AGE: Years | Months | Days 5 If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Newsboy

11. Industry or business

FATHER 12. Name Samuel

13. Birthplace

MOTHER 14. Maiden Name Lorena Glace

15. Birthplace Baltimore

16 (a) Informant

(b) Address

17 (a) (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 25 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 26 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-44 19, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-17-44 19 to 9-22-44, and that I last saw h alive on 9-22 19 44.

Immediate cause of death Atelectasis — Duration

Due to

Due to

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Simon Clyde Webster M. D.

Address Franklin Sq. Hosp. Date signed 9/27/44

2130

G21054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

G21054
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address. University Hospital
(c) Hospital or institution: Baltimore, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Daniels
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mc Cauley
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-44

8. AGE: Years	Months	Days	If less than one day
			2 hr. 15 min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Garlin Mc Cauley
13. Birthplace Virginia

MOTHER
14. Maiden Name Edith Minor
15. Birthplace Victory Mills, N. Y.

16 (a) Informant Mrs. Edith McCauley
(b) Address Daniels, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22 1944, at 1208 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1944 to 9-22 1944, and that I last saw him alive on 9-22 1944.

Immediate cause of death	Duration
Respiratory & cardiac failure	
Due to Circulatory collapse	
Due to Anoxemia	
Other Conditions Premature sep placenta (maternal)	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard C Brown M. D.
Address University Hosp Date signed 9-22-44

VS 3

F 2179

G21055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

$30

G21055 Registered No.

MARGIN RESERVED FOR BINDING. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4408 Kathland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4408 Kathland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN W. ROBINSON

3 (b) If veteran, name war: --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Florence G. Robinson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/16/1870

8. AGE: Years	Months	Days	If less than one day
74	8	7	hr. min.

9. Birthplace Barstow, Md. (Town, county, and state)
10. Usual Occupation Retired Captain
11. Industry or business Balto. Police Dept.

FATHER
12. Name John W. Robinson
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Bordley
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. W. Avery Sinclair, Daughter
(b) Address 4408 Kathland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/26/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Balto., Md.

SEP 26 1944 Huntington Wilson

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1944, at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jul 1944, to Sept 23 1944, and that I last saw h/im. alive on Sept 21 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	3 days
Due to Hypertension	
Due to Arteriosclerosis	
Other Conditions Hypertrophy of Prostate (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 710 Cathedral Sts Date signed 9/25 M. D.

G21056 ✓ G21056

JO #87178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 705 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Adrian Duke

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1918

8. AGE: Years	Months	Days	If less than one day
25	11	27	hr. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER
12. Name Harry Wells
13. Birthplace Kentucky

MOTHER
14. Maiden Name May Rose
15. Birthplace Kentucky

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27-44 (month) (day) (year)
(c) Cemetery or crematory Friendship
Location Anne Arundel Co Md

18 (a) Funeral director Wm Pilliner Sons
(b) Address North & Pa Ave

19 (a) (Date rec'd by registrar) (b)

VS Form 10a SEP 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/19 1944, at 6 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/29 1944, to 9/19 1944, and that I last saw h.. alive on 9/19 1944.

Immediate cause of death	Duration
Chronic Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Shea Halle M. D.
Address Balt City Hosp Date signed 9/19/44

G21057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46c

G21057 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3043 Fleetwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3043 Fleetwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Ellen Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Wm. N. Williams
6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) May 2 1872

8. AGE: Years	Months	Days	If less than one day
72	4	23	hr. min.

9. Birthplace Carroll Co
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm. Houck
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jane Taylor
15. Birthplace Md.

16 (a) Informant Wm. N. Williams
(b) Address 3043 Fleetwood Ave

17 (a) Burial (b) Date thereof 9-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Baltimore, Md.

18 (a) Funeral director L. J. Keyser
(b) Address 5302 Harford Rd.

19 (a) (b) Huntington Williams, M.D.

SEP 26 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1944, at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1943, to Sept 25 1944 and that I last saw h[er] alive on Sept 25 1944.

Immediate cause of death	Duration
Carcinoma of Duodenum	6 mo.
Due to Old Duod. ulcer	
Due to	
Other Conditions Diabetes Mell. Chr. Hypertrophic Arthritis. (Include pregnancy within 3 months of death)	12 yr.

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted]
Address 2020 N. Charles Date signed 9/25/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G21058 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2809 E Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2809 E Preston St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Gehring

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife. John D. Gehring
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 12 1868

8. AGE: Years	Months	Days	If less than one day
76	7	12	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Peter Leonard
13. Birthplace Ireland

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant John D. Gehring - Husband
(b) Address 2809 E Preston

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Rych
(b) Address 2365 Harford Rd

19 (a) (Date rec'd by registrar) (b) Huntington Williams

SEP 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1944 to Sept 24 1944 and that I last saw her alive on Sept 24 1944

Immediate cause of death	Duration
Mitral Regurgitation	11 D.
Terminal	
Due to Arteriosclerosis	11 D.
Hypertension	11 D.
Due to Chr. Interstitial Nephritis	11 D.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature J. J. Stevens
Address 2878 Harford Rd Date signed 9-26-44 M. D.

G21059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G21059 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3205 Rueckert Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country Rueckert

3 (a) FULL NAME Evelyn M. Dietrich

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband ~~or wife~~ Joseph Edward Dietrich
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-14-1914

8. AGE: Years 30 | Months 4 | Days 10 | If less than one day ..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Edward H. W Hensing
13. Birthplace Md.

MOTHER
14. Maiden Name Catherine M. Wigmon
15. Birthplace Md

16 (a) Informant Edward H. Hensing
(b) Address 3205 Rueckert Ave.

17 (a) Burial (b) Date thereof 9-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) ..... (b) .....
(Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1944, to 9-24 1944, and that I last saw h[illegible] alive on 9-24 1944.

Immediate cause of death

Due to Brain tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Rueckert
Address University Hosp. Date signed 9-24-44
M. D.

G21060

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G21060 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2316 Mayfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2316 Mayfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Emma M. Hemplings

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER 12. Name Henry Wagandt
13. Birthplace Germany

MOTHER 14. Maiden Name Catherina Hillmann
15. Birthplace Germany

16 (a) Informant Mr Henry Hemplings
(b) Address 2316 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 27. 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location

18 (a) Funeral director L. J. Ruark
(b) Address 1305 Harford Rd

19 (a) (b)

SEP 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept-24-1944 at 6:30 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 10 1944 to Sept 24 1944, and that I last saw h[illegible] alive on Sept 24 19 44

Immediate cause of death	Duration
Meningeal Hemorrhage	1wk.
Pulmonary Edema	
Due to Exsacerbation	6yrs.
Due to Fracture Hip	
Other Conditions Chronic Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. G. Geyer M.D.
Address 56 W. Melton Ave Date signed 9/25/44

C21061
JL. - 89246

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1318

Registered No. C21061

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 20
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Jordan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Brown

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 7, 1900

8. AGE: Years	Months	Days	If less than one day
44	6	13	hr. min.

9. Birthplace S. C.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business Self

FATHER
12. Name Nash
13. Birthplace ?

MOTHER
14. Maiden Name Nancy Thomas
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Sep 27 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director A. J. Halstead
(b) Address 918 Druid Hill Ave.

19 SEP 26 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/20 19 44, at 1 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/2 19 44 to 9/20 19 44, and that I last saw him alive on 9/20 19 44.

Immediate cause of death	Duration
Chronic Pulmonary Tuberculosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Elmer Hall M. D.
Address Balt City Hosp Date signed 9/20/44

G21062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

67

Registered No. G21062

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. Wise Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel Pearson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/19/44

8. AGE: Years | Months 3 | Days 3 | If less than one day ....hr. ....min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Leroy Pearson
13. Birthplace Apex, N. C.

MOTHER 14. Maiden Name Esther Smith
15. Birthplace Durham, N. C.

16 (a) Informant Mr. Pearson
(b) Address Wise Ave, Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) SEP 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1944, at 1:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Scurvy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature Robert L. Gaither M.D. Medical Examiner.
Date signed Sept 23 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G21063

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G21063

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21days
(e) Length of stay in Baltimore (yrs., mos., or days) 21days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1606 ~~Mt~~ Moore Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Mo untown

3 (a) FULL NAME Baby Girl Stevenson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-4-44

8. AGE: Years	Months	Days	If less than one day
		21	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Joe Stevenson
13. Birthplace Md

MOTHER
14. Maiden Name Susie
15. Birthplace

16 (a) Informant Susie Stevenson
(b) Address 1606 Mt Moore Court

17 (a) Burial (b) Date thereof 9/26/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Ely. H. Kelson
(b) Address 1303 Freelman St

Date SEP 26 1944 (Signature) Huntington Williams Md

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25 1944 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-4 1944 to 9-25 1944 and that I last saw her alive on 9-25 1944

Immediate cause of death prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W D Lyon M. D.
Address Univ Hosp. Date signed 9-25-44

G21064

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G21064 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos. 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 School Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Scott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edward

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1912

8. AGE: Years 31 | Months 10 | Days 17 | If less than one day hr. min.

9. Birthplace South Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Walter Strudice
13. Birthplace South Carolina

MOTHER
14. Maiden Name Pearl Fincher
15. Birthplace South Carolina

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Chas. B. Kelly
(b) Address 1303 Pennsylvania Ave

19 SEP 26 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1944, at 6:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death: Pulmonary tuberculosis, Bilateral, far advanced — Duration 7

Due to

Due to

Other Conditions Tuberculous laryngitis — 7

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H M Phillips M. D.
Address Balt. City Hosp Date signed 9-26-44

G21065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G21065 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2708 Overland Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Overland Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Harry Boyd

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Addison Boyd | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1868

8. AGE: Years 75 | Months 11 | Days 7 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Unknown Boyd
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Elizabeth Boyd
(b) Address 2708 Overland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Henry F. Weikel
(b) Address [illegible]

SEP 26 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/23 1944; at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/12 1944 to 9/23 1944 and that I last saw him alive on 9/22/1944

Immediate cause of death: Myocardial Degeneration — Duration UNKNOWN

Due to: Arteriosclerosis — "
Senility — "

Due to: —

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 6306 Belair Rd Date signed 9/23/44

G21066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 123

Registered No. G21066

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden ave & Madison St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 W
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 513 W. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wm. Loyal Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Gertrude Garner
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1872

8. AGE: Years	Months	Days	If less than one day
72	3	20	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Collector
11. Industry or business

FATHER
12. Name George F. Johnson
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Lorraine
15. Birthplace Virginia

16 (a) Informant Gertrude Johnson
(b) Address 513 W. Baltimore St.

17 (a) Burial (b) Date thereof Sept 27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Baltimore Md

18 (a) Funeral director Harry H. Witzke
(b) Address 401 Edmondson Ave

19 (a) (Date rec'd by registrar) Huntington Williams M.D. Registrar

SEP 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1944 at 12:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1944 to 9/24 1944, and that I last saw him alive on 9/24 1944

Immediate cause of death	Duration
Gastro Intestinal Hemorrhage Etiology undetermined	
Due to	
Due to	
Other Conditions Congestive heart failure	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature J. Carl Myers M. D.
Address Md. Gen. Hosp. Date signed 9/24/44

G21067

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G21067

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. WRITE IN SPACE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2322 Milliman St.,
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 13
(d) Street No. 2322 Milliman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Herman

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Rudolph
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): March , 1881

8. AGE: Years: 63 | Months: 6 | Days: | If less than one day: hr. min.

9. Birthplace: Czechoslovakia (Town, county, and state)
10. Usual Occupation: housewife
11. Industry or business

FATHER
12. Name: Joseph Suda
13. Birthplace: Czecho

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Czecko

16 (a) Informant: husband
(b) Address: 2322 Milliman St.,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept27/44 (month) (day) (year)
(c) Cemetery or crematory: Oak Hill
Location: Horner's Lane

18 (a) Funeral director: Charles E. Schimunek
(b) Address: 2601-03 E. Madison St. M.P.

SEP 26 1944 (Date received by Registrar) Waiting for Physician's M.P.

Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1944, at 5 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 16 1939 to Sept. 24 1944, and that I last saw her alive on Sept. 23 1944

Immediate cause of death: Carcinoma of Liver

Due to: Secondary to Carcinoma of Right Breast

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: Feb. 1939

Major findings of operation: Carcinoma of Right Breast

of autopsy:

Duration
6 mos
4½ yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature: Vincent F. Kosta M.D.
Address: 845 N. Patterson Pk. Ave. Date signed: 9/25/44

G21068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G21068

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1017 N Stricker Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1017 N Stricker Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Pierce

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife unknown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
70			hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Steam Ships

FATHER
12. Name unknown
13. Birthplace Va.

MOTHER
14. Maiden Name unknown
15. Birthplace Va.

16 (a) Informant John Barley
(b) Address 514 N Carrollton Ave

17 (a) Burial (b) Date thereof Sept 27 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A P Co Md

18 (a) Funeral director Isaiah R Brown Sons
(b) Address 108 W Montgomery Street

19 (a) (b)
(Date rec'd by Registrar) Registrar

VS 6 SEP 28 1944 Huntington Hillsboro, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24/1944, at 730 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/31/1944 to 9/24/1944 and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to	
Due to Arteriosclerosis	
Other Conditions Syphilis	5 Yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Barley
Address 514 N Carrollton Date signed 9/26/44 M.D.

G21069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21069 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Glen Burnie, P. O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Old Ebony Beach
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert H. Stallings

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-05-2149

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1887

8. AGE: Years 57 | Months 8 | Days 19 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Day Laborer

11. Industry or business Davidson Chem. Co.

FATHER
12. Name Francis Stallings
13. Birthplace Md.

MOTHER
14. Maiden Name Lizzie May Hall
15. Birthplace Md.

16 (a) Informant Mrs. Bessie Huber
(b) Address Valley, Glen Burnie P.O., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29 44 (Month) (day) (year)

(c) Cemetery or crematory Cedarhill
Location Cape, Md

18 (a) Funeral director Howard Evans
(b) Address Glen Burnie, Md.

19 (a) SEP 28 1944 (Date rec'd by registrar) (b) [illegible], M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1944, at 8:25 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 26 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21070

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21070

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1906 Mosher St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - (City) (If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 Mosher St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Howard D. B. McAbee (Alias; Edward D. West)

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. 213-10-0677

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ella M. Maybee (nee Gaulup)

6 (c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1882

8. AGE: Years 61 | Months 9 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Philadelphia, Pa. (Town, county, and state)

10. Usual Occupation Police Watchman

11. Industry or business Balto. Transit Co.

FATHER
12. Name Charles K. Maybee
13. Birthplace Pa.

MOTHER
14. Maiden Name Emma Wagner
15. Birthplace Pa.

16 (a) Informant Mrs. Ella M. McAbee (Wife)
(b) Address 1906 Mosher St. (17)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cem.
Location A A Co., Md.

18 (a) Funeral director C. Howard Evans
(b) Address 1400 S. Charles St. (30)

19 (a) (b) (Registrar)

SEP 26 1944

Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1944 at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2, 1944, to Sept 25, 1944, and that I last saw him alive on Sept 24, 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Perkins M. D.

Address 203 Catalpa Rd. Date signed 9/26/44

G21071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52 R

G21071
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5102 Eugene Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5102 Eugene Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANIEL J. REEVES

3 (b) If veteran, name war

3 (c) Social Security Account No. 717-07-8436

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Catherine M. Reeves
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1876

8. AGE: Years	Months	Days	If less than one day
68	6	12	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business P. R.R.

FATHER
12. Name Theo. Reeves
13. Birthplace England

MOTHER
14. Maiden Name Eliz. Furlong
15. Birthplace Balto., Md.

16 (a) Informant Mrs. D. J. Reeves
(b) Address 5102 Eugene Ave., Balto.

17 (a) burial (b) Date thereof Sept. 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto., Md.

18 (a) Funeral director Lowe's Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date received by Registrar) (b) Registrar
SEP 26 1944 Huntington Millard, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25, 1944, at 5:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 26 1944 to Aug 21 1944. and that I last saw h im alive on Aug 21 1944.

Immediate cause of death	Duration
Toxemia	2 mos
Due to Carcinoma of Urinary Bladder	3 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Feb 26 1944
Major findings of operation:
Extensive C.A. of Bladder
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Francis M. Gillis M. D.
Address 1800 N. Charles St. Date signed 9/26/44

G21072

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55D

G21072 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. Every item of correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4109 Woodlea Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Woodlea Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALVINA M. LEHNEIS

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife J. Adam Lehneis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	18	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Schutz
13. Birthplace Unknown

MOTHER
14. Maiden Name Amalie Niemann
15. Birthplace Unknown

16 (a) Informant Mrs. H. A. Feick,
(b) Address 4109 Woodlea Ave.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Sept. 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Md.

18 (a) Funeral director Lanahan Funeral Home
(b) Address 7401 Belair Road

19 (a) (Date received by registrar) (b) Registrar

VS 150 SEP 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24th, 1944, at 9:30 PM

21. I certify that death occurred on the date above stated, that I attended deceased from July 6 1944 to Sept 24 1944, and that I last saw h alive on 19

Immediate cause of death

Due to Convulsions of Right Arm Hemiplegia Cer. Hemorrhage

Due to Old age

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hunt Lent C. Blake M. D.
Address Med. Arts Bldg Date signed

Huntington Williams, M.D.

G21073

G21073

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3206 Milford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3206 Milford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Louise Curry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Francis A. Curry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 8 1882

8. AGE: Years	Months	Days	If less than one day
62		17	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name James G. Phelps
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Regina M. Thompson
15. Birthplace Baltimore Md

16 (a) Informant Francis A. Curry
(b) Address 3206 Milford Ave

17 (a) Burial (b) Date thereof Sept 28 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Henry H. Thomas
(b) Address 4204 Ridgewood Ave

SEP 26 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1944 2:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 19 44 to Sept. 25 1944, and that I last saw h[illegible] alive on Sept. 24 1944:

Immediate cause of death	Duration
Pulmonary Edema	4 days
Uremia	6 days
Due to Auricular Fibrillation	5 yrs.
Mitral Regurgitation	5 yrs. ?
Due to Chr. Interstitial Nephritis	5 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 4600 Liberty Hgts. Date signed 9/25/44

G21074

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G21074 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 9/19/44
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 41 E. Hill Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME SAMUEL BLAKLEY DONNAN

3 (b) If veteran, name war -

3 (c) Social Security Account No. 217-09-9021

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillian Brady
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) Mar. 5, 1906

8. AGE: Years	Months	Days	If less than one day
38	6	21	hr. min.

9. Birthplace Cambridge, Maryland
(Town, county, and state)
10. Usual Occupation Deck Engineer
11. Industry or business Merchant Marine

FATHER
12. Name Samuel B. Donnan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Kimmey
15. Birthplace Cambridge, Md.

16 (a) Informant Records, U. S. Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Anne Arundel Co. Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light St.

SEP 26 1944 (a) (Date received by Local Registrar) (b) Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH September 26, 1944, at 6:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19, 1944, to Sept. 26, 1944, and that I last saw him alive on Sept. 26, 1944.

Immediate cause of death 1. Tertiary syphilis with syphilitic aortitis and marked involvement of the mouths of the coronary arteries. — Duration Unk.
2. Marked myocardial degeneration and necrosis - due to #1

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature J. C. Abbott M. D.
Address Baltimore, Md. Date signed 9/26/44

MS-55569

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21075

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

G21075 ✓ 131a Reg. Dist. No.

1. PLACE OF DEATH:

County

City or town: Balto. Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 2248 Brookfield Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant, give residence of mother)

State: Md County

City or town: Balto. (If outside city or town limits, write RURAL and give nearest town)

Street No.: 2248 Brookfield Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Joseph S. Kaufman

3. (b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 17 1881

8. AGE: Years 63 | Months 7 | Days 18 | If less than one day: hrs. ____ min.

9. Birthplace: Balto. Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Charles Kaufman

13. Birthplace: Germany

MOTHER — 14. Maiden name: Babetta Stern

15. Birthplace: Germany

16. Informant: Lawrence J. Kaufman

Address: 2248 Brookfield Ave

17. Burial (Burial, cremation, or removal): Date thereof: Sept 28 1944 (Month) (day) (year)

Cemetery or crematory: Rep. Shalom Cemetery

Location: O'Donnell St

18. Funeral director: Abend & Co

Address: 2432 Reisterstown Rd

SEP 27 1944 (Date rec'd by registrar)

19. Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1944, at 11:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 6 1944 to Sept. 25 1944

and that I last saw h... alive on Sept. 25 1944

	DURATION
Immediate cause of death: Chronic nephritis	7
Due to: Arteriosclerosis	7
Due to:	
Other conditions: Eczema	

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) — Injured at work?

Means of injury

22. SIGNATURE: Sidney D. Levy, M. D. or other

Address: 2322 Eutaw Place — Date signed: 9-26-44

G21076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G21076

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3203 Homewood Ave
(c) Hospital or institution —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 yr
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3203 Homewood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Jeanette T. Wilhelm

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John M Wilhelm
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1867

8. AGE: Years 77 | Months — | Days — | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Clerk
11. Industry or business:

FATHER
12. Name: George Clark
13. Birthplace: Ireland

MOTHER
14. Maiden Name: M. Dunn
15. Birthplace: Ireland

16 (a) Informant: Mr. Wilhelm
(b) Address: 3203 Homewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-26-44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location:

18 (a) Funeral director: Mary M. Wiedefeld
(b) 1524 Huntington Ave Balto Md

19 (a) SEP 27 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/ 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/ 1944 to 9/26/ 1944
and that I last saw h alive on 9/25/ 1944.

Immediate cause of death	Duration
Myocardial Insufficiency	1 month
Due to Myocarditis	5 yrs
Due to Generalized Arteriosclerosis	5 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Thomas J Mark M.D.
Address 532 E 22nd St Date signed 9/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C21077

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C21077

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 653 Bartlett Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) - 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 653 Bartlett Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick McNeil Kerrone

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66	=		hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation =
11. Industry or business Police Officer

FATHER
12. Name Peter McNeil Kerrone
13. Birthplace Ireland

MOTHER
14. Maiden Name Ella Blandford
15. Birthplace Mary Land Irish

16 (a) Informant Mrs. Mary McNeil Kerrone
(b) Address 653 Bartlett Ave

17 (a) Burial (b) Date thereof 9-27-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location =

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 501 E 22nd St

19 SEP 27 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24 1944, at 04 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 1944 to 9/24 1944 and that I last saw h alive on 9/20 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	8 hours
Due to Generalized Arteriosclerosis	6 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury Thomas Fulton Ford

23. Signature Thomas Fulton Ford M. D.
Address 532 E 22nd St Date signed 9/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21078

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21078 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 E. 22nd Sts. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Deming

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months - | Days - | If less than one day: hr. min.

9. Birthplace Manchester England (Town, county, and state)

10. Usual Occupation

11. Industry or business Retired Actor

FATHER
12. Name William Deming
13. Birthplace Manchester England

MOTHER
14. Maiden Name Emily Evelt
15. Birthplace Manchester England

16 (a) Informant Geo Lou Deming
(b) Address 306 E. 22nd Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M. Wedderick
(b) Address 501 E 22nd St

SEP 27 1944 (b) (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25/44 19 , at 10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1/44 19 , to 9/25/44 19 , and that I last saw him alive on 9/25/44 19

Immediate cause of death: Coronary Thrombosis — Duration

Due to

Due to

Other Conditions: Diabetic Mellitus, Diabetic Gangrene of Right Toe

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: 1) Coronary Occlusion 2) Hydrops of Gall Bladder

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius Fleck

Address Franklin Square Hosp. Date signed 9/25/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G21079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E ✓

Registered No. G21079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Md
(b) Street address 2915 Edmondson Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 2915 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Burns

3 (b) If veteran, name war —

3 (c) Social Security Account No. No

4. Sex Female

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Robert A Burns (Deceased)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 31. 1873

8. AGE: Years 71 Months Days 25 If less than one day hr. min.

9. Birthplace Balto md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James W. Reilly
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Jorgensen
15. Birthplace Ireland

16 (a) Informant Mrs. Alice Krueger.
(b) Address 623 Appleton St

17 (a) Burial (b) Date thereof 9 28 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Balto City Md.

18 (a) Funeral director Durand & Brannon
(b) Address 2924 Edmondson Ave

19 SEP 27 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 20 1944 to Sept 25 1944, and that I last saw deceased alive on Sept 25 1944.

Immediate cause of death Carcinoma of Intestines

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1729 W Lombard Date signed 9-26-44

G21080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a ✓ G21080 Registered No. (over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division Street
(c) Hospital or institution Provident Hospital 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7½ hr.
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 N. Mount St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Olive Ealy or Ollie V. Foster

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced. Married William Foster

6 (b) Name of husband or wife (John H. Ealy)

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Fla.
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER 12. Name ? Johnson.

13. Birthplace unknown.

MOTHER 14. Maiden Name unknown.

15. Birthplace Jacksonville. Fla.

16 (a) Informant John H. Ealy

(b) Address 214 N. Mount St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Cabrary Cem.

Location A. A. Co. Md.

18 (a) Funeral director Grace H. Alexander.

(b) Address 927 N. Mount St.

19 (a) (Date rec'd by registrar) (b) mr

SEP 27 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23, 1944, at 8:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1944, to 9/23 1944, and that I last saw h alive on 19

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature G. L. Benfield

Address Provident Hosp Date signed 9/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓ G21081
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. 04
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 Belmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Jozefa b. Papuga

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife John Papuga

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Suzlik
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs Mary Goodwin
(b) Address 4616 Marble Hall Road

17 (a) Burial (b) Date thereof Sept 28/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory St. Stanislaus Location

18 (a) Funeral director Stefan J. Frankowski
(b) Address 1009 N. Kenwood Ave

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) Registrar

SEP 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1944, at 7:45 AM

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions Pulmonary emphysema

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Fratcher M.D.
Medical Examiner.
Date signed Sept. 26 1944

G21082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

59B

G21082 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 Ethridge St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 Ethridge St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Catherine Tippett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/15/1879

8. AGE: Years 65 | Months | Days 10 | If less than one day hr. min.

9. Birthplace St. Marys Co. Md
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Chas. W. Tippett
13. Birthplace St. Marys Co. Md.

MOTHER
14. Maiden Name Catherine Reid
15. Birthplace St. Marys Co. Md

16 (a) Informant Miss Minnie Tippett
(b) Address 1113 Ethridge St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Charles R. Lawe
(b) Address 802 Madison Ave.

19 SEP 27 1944 Huntington Williams M.D.
Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1944, at 3:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1944 to Sept 25 1944, and that I last saw h[illegible] alive on Sept 25 1944.

Immediate cause of death: Chronic Arthritis — Duration: One yr.

Due to: — Duration: 3 yrs.

Due to: —

Other Conditions: None

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. Patterson M. D.
Address 817 Hamilton Ave. Date signed

G21083

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21083 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 17 W. Cross St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 17 W. Cross St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Schuyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1857

8. AGE: Years	Months	Days	If less than one day
87			hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 9-27-44
(Burial, cremation, or removal) (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Lee Oden
(b) Address 4644 York Rd

19 SEP 27 1944 (b) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1944, at 5 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 26 1944

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21084

NIKIRK

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G21084 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Frederick
(c) City or town Middletown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles E. Nikirk

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife Sara Nikirk
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1861

8. AGE: Years 83 | Months 11 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name George Nikirk
13. Birthplace Middletown, Md.

MOTHER
14. Maiden Name Madeline Bechtel
15. Birthplace Middletown, Md.

16 (a) Informant Blanche Nikirk
(b) Address Frederick, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30, 44 (month) (day) (year)
(c) Cemetery or crematory Reformed
Location Middletown, Md.

18 (a) Funeral director Gladhill Co.
(b) Address Middletown, Md.

SEP 27 1944 (a) (Date received by Registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1944, at 1 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1944, to 9-27 1944, and that I last saw him alive on 9-26 1944.

Immediate cause of death Respiratory failure — Duration

Due to Uremia

Due to Kidney failure

Other Conditions Prostatic Hypertrophy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Palmer

Address University Hospital Date signed 9-27 1944 M. D.

G21085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G21085

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Roseberg (If outside city or town limits write RURAL and give town)
(d) Street No. 910 Rosedale Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John R Strotmeyer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Marie Strotmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years	Months	Days	If less than one day hr.	min.
36				

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Metler
11. Industry or business Overseer Standard Radiator & Sanitary Co

FATHER
12. Name John R. Strotmeyer
13. Birthplace Md.

MOTHER
14. Maiden Name Christine Hellmer
15. Birthplace Md.

16 (a) Informant Marie Strotmeyer
(b) Address 910 Rosedale Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Govans Road

18 (a) Funeral director Glauner & Hoffman
(b) Address 1639 N Broadway

19 (Date received) SEP 27 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1944, at 12:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-11 1944, to 9-24 1944, and that I last saw h[illegible] alive on 9-24 1944.

Immediate cause of death	Duration
Kidney Failure	
Due to Burns 3rd degree	
Due to	
Other Conditions	

Autopsy
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident 26/6
(b) Date of occurrence 9-11-44 at M
(c) Where did injury occur? Balto. Md
2315 Holabird Ave (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial Place While at work? Yes
(Specify type of place)
(e) Means of injury Burned

23. Signature M. Reinhart
Address Univ. Hosp. Date signed 9-24-44 M. D.

VS 150 Ref. St. Hd. Recommended by Home of J. Maddux, M.D.

G21086

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G21086 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 214 N. Hilton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 214 N. Hilton St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES HOWARD HENSCHEN, SR.

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 16, 1885

8. AGE: Years: 59 | Months: 4 | Days: 8 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Retired Cigar Box Mfgr.

11. Industry or business

FATHER
12. Name: Henry C. Henschen
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Louisa Sibyl
15. Birthplace: Balto., Md.

16 (a) Informant: Mrs. Minnie Henschen
(b) Address: 214 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/27/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) SEP 27 1944 (b) Huntington Williams M.D. 818 Edmondson Ave

VS

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24, 1944 at 1:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 19 to Sept 23 1944. and that I last saw him alive on Sept 23 1944.

Immediate cause of death: Bronchio-pneumonia

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Van Schuyck M.D.
Address 818 Edmondson Ave Date signed 9/26/1944

G21087

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117B

Registered No. G21087

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 42 y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 15
(If outside city or town limits, write RURAL and give town)
(d) Street No. Druid Pk Apts. 3000 Reisterstown Rd.
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Boyd G. Weber

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Violet B. Weber
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 15 1881

8. AGE: Years 63 | Months 5 | Days 10 | If less than one day: hr. min.

9. Birthplace W. Va. Berkley Springs
(Town, county, and state)

10. Usual Occupation: Retired
11. Industry or business: Coal Dealer

FATHER
12. Name: Goethlieb Weber
13. Birthplace: W Va

MOTHER
14. Maiden Name: Unknown
15. Birthplace:

16 (a) Informant: Mrs. Violet B. Weber
(b) Address: 3000 Reisterstown Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. Pickner & Son
(b) Address: Balto. Md.

19 (a) SEP 27 1944 (Date received by Registrar)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/25 1944, at 9:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/25 1944 to 9/25 1944 and that I last saw h alive on 9/25 1944.

Immediate cause of death	Duration
Due to Generalized Peritonitis	
Due to Perforated duodenal	
Other Conditions Ulcer	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
Same
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: H. M. N. Crosby
Address: Mercy Hosp. Date signed 9/25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

G21088

CERTIFICATE OF DEATH

Registered No. G21088 1210

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 E. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1802 E. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY EVELYN BAROFF

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divoreed

6 (b) Name of husband or wife Archibald
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 30, 1874

8. AGE: Years	Months	Days	If less than one day
70	3	25	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sally Forwood
15. Birthplace Harford Co., Md.

16 (a) Informant Mrs. Edward J. Green
(b) Address 2313 W. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) SEP 27 1944 (b) (Date received by registrar) Registrar

VS 184

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 1944, at 8:40P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1944 to Sept. 25 1944, and that I last saw h[illegible] alive on Sept 25 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 hour
Due to Mitral Regurgitation	2 days
Due to Arteriosclerosis Hypertension	20 yrs
Other Conditions Chr. Interstitial Nephritis	20 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T. F. A. Stevens M. D.
Address 2878 Harford Rd Date signed 9-26-44

G21089

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21089
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1245 N. Bentalou St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1245 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Simmons B. Marman

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	212-12-6337

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Bertie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1876

8. AGE: Years	Months	Days	If less than one day
68	0	16	hr. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual Occupation Shipping Clerk
11. Industry or business Ward's Bakery

FATHER
12. Name Gitner Marman
13. Birthplace Frederick, Md.

MOTHER
14. Maiden Name --
15. Birthplace

16 (a) Informant Mr. Albert E. Marman
(b) Address 1245 N. Bentalou St. 17

17 (a) Burial (b) Date thereof 9/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 27 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26- 1944, at 2:15 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mallett M.D.
Medical Examiner.
Date signed 9-26-44

G21090
120493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G21090
Registered No. (1942)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 16
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 N Gilmor St
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Wade Griffin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	black	married

6 (b) Name of husband or wife Mamie Griffin
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) 4-5-84 1886

8. AGE: Years	Months	Days	If less than one day
58 60	5	21	.....hr. .....min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Baggage Porter
11. Industry or business

FATHER
12. Name Lewis Griffin
13. Birthplace Md.

MOTHER
14. Maiden Name Eliza Brooks
15. Birthplace Md.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 1, 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lyon Chapel
Location Md.

18 (a) Funeral director Leg. H. Nelson
(b) Address 1303 Pennsylvania Ave Huntingdon Pa.

19 (a) (b)
(Signature of local registrar) Registrar

SEP 27 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1944 at 1:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from.....19....., to.....19.....
and that I last saw h..... alive on.....19.....

Immediate cause of death Lobar pneumonia

Due to RUL, RML, RLL Lobe due to

Due to pneumococcus type

Other Conditions 14

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy:.....

Duration
18 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature John R. Bennengton M. D.
Address Dist H Date 9/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

70

G21091
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 718 Dolphin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 Wilson Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Juanita Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/23/43

8. AGE: Years 1 | Months 197 | Days 3 | If less than one day hr. min.

9. Birthplace Balto. Md
(Town, county, and State)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Harry Smith
13. Birthplace Md

MOTHER
14. Maiden Name Bertha Graham
15. Birthplace Md.

16 (a) Informant Harry Smith
(b) Address 529 Wilson St

17 (a) Burial (b) Date thereof 9/29/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Jos. B. Kelson
(b) Address 1303 Pennsylvania Ave
(Undertaker or Mortician)

19 (a) SEP 27 1944 (b)
(Date received by Registrar) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 19 44 at 9:25 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Meningitis, purulent

Due to

Other Conditions Rickets

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Manner of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Sept 26 1944

G21092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63a

Registered No. G21092

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3008 Clearview Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Clearview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH HENRY LUCAS

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Alice R. Lucas
6 (c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May, 28, 1878

8. AGE: Years: 66 | Months: 3 | Days: 28 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: Postal Clerk

11. Industry or business: U.S. Gov.

FATHER
12. Name: ? Lucas
13. Birthplace: Baltimore, Md

MOTHER
14. Maiden Name: Annie Rowe
15. Birthplace: Maryland

16 (a) Informant: Mrs. Alice R. Lucas
(b) Address: 3008 Clearview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore
Location: Baltimore, Md.

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway- 13

19 SEP 27 1944 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1944, at 3.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1941, to Sept 1944.
and that I last saw h alive on 9-23 1944

Immediate cause of death	Duration
Cerebral hemorrhage	1 hour
Due to arterial Hypertension	4 Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peake M. D.
Address 4508 Harford Rd Date signed 9-26-44

C21093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1137a

Registered No. C21093

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 3307 Eaton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Henry Booker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Georgianna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1870

8. AGE: Years 74 | Months — | Days — 17 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Merchant

11. Industry or business

FATHER 12. Name William H. Booker

13. Birthplace Petersburg, Va

MOTHER 14. Maiden Name Mary King

15. Birthplace Richmond, Va

16 (a) Informant Grace V. Blackstone

(b) Address 1708 N. Gilbert St.

17 (a) Burial (b) Date thereof Sept. 27, 1944 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park

Location Baltimore Co. Md.

18 (a) Funeral director Wm. Leyd. A. Holland

(b) Address 1631 N. Druid Hill Ave.

19 (a) (b) Huntington Williams, Md.
(Date received by Registrar)

SEP 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1944, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-3 1944 to 9-24 1944, and that I last saw h~~im~~ alive on 9-24 1944.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to Prostatectomy	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9-8

Major findings of operation: Hypertrophied Prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address 803 N. Fremont Ave. Date signed 9-25-44

G21094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 57 F

G21094
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Rural, York, Route #4
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #4
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Russell C. Harbold

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lottie Harbold
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1901

8. AGE: Years	Months	Days	If less than one day
43	3	12	23 hr. 30 min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name John A. Harbold
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Alice Myers
15. Birthplace Pennsylvania

16 (a) Informant Deceased
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/27/44 (month) (day) (year)
(c) Cemetery or crematory Shiloh
Location York Co.

18 (a) Funeral director Wm. J. Stephens & Son
(b) Address North & Penna Ave's

19 (a) (Date) SEP 27 1944 (b) Registrar Washington Hill Brown M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26 1944 at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 1944 to 9/26 1944 and that I last saw him alive on Sept. 26 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Edema	72 hrs.
Due to Neoplasm of Spinal Cord. Type: pending on pathological report	6-7 mos
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation Sept. 23, 1944
Major findings of operation: Neoplasm of spinal cord, region 8th C. & 1st T. Biopsy
If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. E. Steinbrook M. D.
Address Mercy Hospital Date signed 9/26/44

G21095

AB-88693

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

G21095

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 3rd
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7hrs. 40min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
Street No. 531 S. Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lindsey -Twin B

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: Col

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 21-1944

8. AGE: Years | Months | Days | If less than one day: 7 hr. 40 min.

9. Birthplace Baltimore-Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Carl Lindsey
13. Birthplace Md.

MOTHER
14. Maiden Name Anita Lindsey
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremation (b) Date thereof 9-26-44 9PM (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Balto. City Hospitals
Location 4940 Eastern Avenue

18 (a) Funeral director
(b) Address

19 SEP 27 1944 Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21- 1944 at 8.10AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept- 21- 19 44 to Sept-21 1944, and that I last saw him alive on Sept-21 1944

Immediate cause of death: Congenital Atelectasis — Duration: 2'40"

Due to

Due to

Other Conditions: Prematurity Breech Delivery
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams Jr. M.D. M.D.
Address Balto City Hosp Date signed 9-25-44

G21096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1190

G21096

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 W. Barre Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Irving Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-26-44

8. AGE: Years | Months: 3 | Days: 28 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Daniel Boone
13. Birthplace Md.

MOTHER
14. Maiden Name Gloria Cunningham
15. Birthplace Md.

16 (a) Informant Gloria Boone
(b) Address 541 W. Barre St.

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Baltimore Md.

18 (a) Funeral director Walter B. Spriggs
(b) Address 139 W. Hamburg

19 (a) (Date received by Registrar) (b) Huntington Williams M.D. Registrar

SEP 27 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 24 1944, at 5:45 P M

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to His death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Diarrhea, Infantile

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature J. L. Wallenmeier M.D.
Medical Examiner.

Date signed Sept. 25 1944

G21097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G21097 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 704 Warner St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Warner St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert James Travers
3 (b) If veteran, name war
3 (c) Social Security Account No. 705-07-7914

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband~~ or wife Hilda Louise Travers
6 (c) If alive, give age 33 years

7. Birth date of deceased (mo., day, yr.) 9 27 1904

8. AGE: Years 40 | Months 1 | Days 30 | If less than one day hr. min.

9. Birthplace Taylor's Island, Md.
(Town, county, and state)

10. Usual Occupation Laborer
11. Industry or business Steel

FATHER
12. Name James Travers?
13. Birthplace —

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Hilda Louise Travers
(b) Address 704 Warner St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9 30 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Balto. Md.

18 (a) Funeral director Walter B. Spigler
(b) Address 139 W. Hamburg St.

19 (a) SEP 27 1944 (b) Huntington Williamsport Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1944, at 5:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1944, to 9/26 1944, and that I last saw him alive on 9/26 1944.

Immediate cause of death Lobar Pneumonia — Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ronald B. Lightstone M. D.
Address 2129 Druid Hill Ave. Date signed 9/26/44

G21098

G21098

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No.

Every item of information should be carefully supplied. Please write plainly, with UNFADING INK. Especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1206 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (ARTHUR BUXBAUM) Arthur Buxbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

MEDICAL CERTIFICATION

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNA BUXBAUM
6 (c) If alive, give age years

20. DATE OF DEATH Sept 26 1944 at 2:00 P M

7. Birth date of deceased (mo., day, yr.) SEPT 1st- 1890

8. AGE: Years	Months	Days	If less than one day
54-	XX	25	hr. min.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

9. Birthplace BALTIMORE. MD.
(Town, county, and state)

10. Usual Occupation NOTARY PUBLIC

11. Industry or business

FATHER
12. Name DAVID BUXBAUM
13. Birthplace DONT KNOW

MOTHER
14. Maiden Name MIRIAM MANKO
15. Birthplace NORFOLK. VA.

16 (a) Informant MRS ANNA BUXBAUM
(b) Address 1206 HOLLINS ST.

17 (a) BURIAL (b) Date thereof SEPT 28-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory BALTIMORE HEBREW CEM
Location GAY ST-BELAIR RD

(a) Funeral director J. Abrams & Co
(b) Address 2432 REISTERSTOWN RD

(c) Date received SEP 27 1944 Registrar Washington Williams

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Charles J. Fulginiti M.D.
Medical Examiner.
Date signed 9/26/44

VS 151

G21099

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160c

G21099
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wallbrook + Caton Aves.
(c) Hospital or institution: St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 30 min
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Sykesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Stem

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 27, 1944

8. AGE: Years | Months | Days | If less than one day: hr. 30 min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Francis Stem
13. Birthplace Md.

MOTHER — 14. Maiden Name Edna May Rosco
15. Birthplace Md.

16 (a) Informant Francis Stem
(b) Address Sykesville, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Ebenezer Cemetery
Location Winfield, Carroll Co, Md

18 (a) Funeral director C. Henry Weer
(b) Address Sykesville, Md.

19 (a) (b) Registrar

SEP 27 1944
VS 18b Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1944, at 6:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1944 to 9-27 1944 and that I last saw her alive on 9-27 1944

Immediate cause of death: Asphyxia in birth canal, due to
Due to: difficult breech extraction
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. E. McGrath M.D. M. D.
Address St. Agnes Hosp Date signed 9-27-44

G21100 G21100

YA-89851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1942

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5224 Park Heights Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Lynn

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 25, 1886

8. AGE: Years 57 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace Kentucky
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Enoch Lynn (d)
13. Birthplace Kentucky

MOTHER
14. Maiden Name Frances Stevens (d)
15. Birthplace Kentucky

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Maryland

18 (a) Funeral director Lorenz Byers
(b) Address 5005 Mt. Hoyt Ave

19 (a) (Date rec'd by registrar) (b) Registrar
SEP 2nd 1944 Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 24 1944, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1944, to 9/24 1944, and that I last saw h. alive on 9/24 1944.

Immediate cause of death: Chronic pulmonary tb. — Duration: 3

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Pulmonary tb. ?

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Shea Halle M. D.
Address Balt City Hosp Date signed 9/25/44

G21101

BALTIMORE CITY HEALTH DEPARTMENT V G21101

CERTIFICATE OF DEATH 302 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 1/2 Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 40 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6019 Old Harford Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT BACKHAUS

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-9956

4. Sex M | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband or wife Mrs. Minnie Backhaus

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 20 Jan 1844

8. AGE: Years 60 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business Miller Bros. Restaurant

FATHER
12. Name Frederick Backhaus
13. Birthplace Germany

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Germany

16 (a) Informant wife
(b) Address 6019 old Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) Date received by local registrar SEP 28 1944 (b) Signature of local registrar Huntington Williams, M.D.

VS 116

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Sept 1944, at 9 P M

21. I certify that death occurred on the date above stated, that attended deceased from Aug 19 44 to 26 Sept 1944 and that I last saw h alive on 26 Sept 1944

Immediate cause of death Cardiac failure — Duration

Due to aortic Valvular disease & insufficiency

Due to Syphilis

Other Conditions Hypertensive Cardiovascular Renal

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Mungavin Jr. M. D.
Address 532 E. University Pkwy Date signed 9/27/44

G21102 | BALTIMORE CITY HEALTH DEPARTMENT | V G21102

CERTIFICATE OF DEATH 83d

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital G-9
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles A Ruppel

3 (b) If veteran, name war — W | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 6th 1873

8. AGE: Years	Months	Days	If less than one day
70	11	21	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Butcher
11. Industry or business Leitch

FATHER
12. Name George Ruppel
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Maurer
15. Birthplace Balto. Md.

16 (a) Informant Mrs Caroline E. Lang
(b) Address 2411 Mayfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/44 (month) (day) (year)
(c) Cemetery Balto. Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.

19 (a) (Signature of registrar) (b) Registrar

SEP 28 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27/44 19 , at 2 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/23 19 44 to 9/27 19 44 and that I last saw h[illegible] alive on 9/27 19 44

Immediate cause of death Cerebro Vascular Accident — Duration

Due to Hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: \

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address St Joseph Hospital Signed 9/27

G21103
329830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G21103
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1417 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Crosby
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: male
5. Color or race: black
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mamie Crosby
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) 11-25-83

8. AGE: Years 60 | Months 10 | Days – | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name George Crosby
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Stewart
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (Registrar's signature) SEP 28 1944 Huntington Williams, Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 19 44 at 9 30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 26 19 44 to Sept 25 19 44 and that I last saw h[illegible] alive on Sept 25 19 44

Immediate cause of death: Generalized debilitation — Duration:
Due to: metastases
Due to: Tumor of kidney
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Extensive metastases to lungs

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph C. Preston
Address Johns Hopkins Hosp Date signed 9-26-44

over

G21104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

940 ✓ G21104 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 225 Carrollton Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levi Wyatt

3 (b) If veteran, name war —
3 (c) Social Security Account No. 216-10-8741

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Delia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 22 1960
8. AGE: Years 44 | Months - | Days 3 | If less than one day hr. min.
9. Birthplace Gloucester Co. - Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Letta Jones
15. Birthplace Va.

16 (a) Informant Mrs Delia Wyatt
(b) Address 732 Pierce St

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans, Md.

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Schroeder St

19 (a) SEP 28 1944 (Date rec'd by registrar) (b) Hunter for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25, 19 44, at 6:45 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed Sept. 25 1944.

VS 151

G21105

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

119a

G21105 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hour
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore - 23 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 W Lexington St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Perdue

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: FEMALE | 5. Color or race: BLACK | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/16/44

8. AGE: Years | Months: 1½ | Days: 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

MOTHER / FATHER
12. Name Willie Perdue
13. Birthplace N. C.
MOTHER
14. Maiden Name Corine White
15. Birthplace Va

16 (a) Informant Corrine Perdue
(b) Address 1010 W. Lexington

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans, Md.

18 (a) Funeral director Mrs Katie R. Williams
Address 222 N Schroeder St

19 SEP 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1944, at 10:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23, 1944 to Sept 25 1944, and that I last saw her alive on Sept 25 1944.

	Duration
Immediate cause of death: Respiratory & Circulatory failure	1 day
Due to: Acidosis	
Due to: Dehydration	4 days
Other Conditions: Diarrhea Newborn	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

23. Signature H. E. Weaks M. D.
Address Main Office Date signed 9/25/44

G21106 ✓ G21106

JL - 82512

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93d Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution:

Baltimore City Hospitals. 19

(d) Length of stay in hospital or inst. (yrs., mos., & days) 1yr. 2m. 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 312 S. Vincent St. (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Viola Queen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1860

8. AGE: Years 84 | Months 4 | Days 12 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Alexander Jones

13. Birthplace Md.

MOTHER

14. Maiden Name Mary Johnson

15. Birthplace Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof Sept. 28, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Mt. Winans, Md.

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N Schroeder St.

19 SEP 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VE 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25 19 44, at 12.35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-3 19 44, to 9-25 19 44, and that I last saw her alive on 9-24 19 44.

Immediate cause of death pulmonary embolism? Arteriosclerotic heart disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. B. Kery, J. M.D.

Address City Hosp Date signed 9-25

G21107

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G21107 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 320 N. Mount St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 N. Mount St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Braxton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Adam Braxton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1880

8. AGE: Years 64 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Anne Arundel Co, Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Washington Waters
13. Birthplace Maryland

MOTHER 14. Maiden Name Lucinda Wallace
15. Birthplace Maryland

16 (a) Informant Sophie Matthews
(b) Address 1431 W. Mulberry St

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans, Md

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3[illegible] Schroeder St

19 SEP 28 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 25 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944, to Sept 25 1944, and that I last saw her alive on Sept 25 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Hypertension	?
Due to Uremia	4 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Shuttard M. D.
Address 1631 W Hamburg St Date signed 9/27/44

G21108

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G21108

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 N. Carey St
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Carey
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James R. Travers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Cd | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of ~~husband or~~ wife Agnes Travers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace W. Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Robert Travers
13. Birthplace W. Va

MOTHER 14. Maiden Name Sarah Mackey
15. Birthplace W. Va

16 (a) Informant Melissa L. Travers
(b) Address 620 N. Carey

17 (a) (Burial, cremation, or removal) (b) Date thereof 9/29/44 (month) (day) (year)

(c) Cemetery or crematory Arbutus M. Park
Location Arbutus, Md.

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St

19 SEP 28 1944 (b) Huntingtn. Williams, Md.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/44 3:10 M

21. I certify that death occurred on the date above stated, that I attended deceased from 9/25 1944 to 9/26 1944 and that I last saw h alive on 9/25/44.

Immediate cause of death	Duration
Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Heidelcome, M.D.

Address 1731 Harlem Ave Date signed 9/27/44

JO G21109

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47d

G21109 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 5N1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15days
(e) Length of stay in Baltimore (yrs., mos., or days) 34 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 Colvin St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Louis Harding

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 4, 1893
8. AGE: Years 51 | Months 6 | Days 22 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Wallace Harding (d)
13. Birthplace Md.

MOTHER
14. Maiden Name Rachel ? (d)
15. Birthplace Md.

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 3rd 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brentland Md
18 (a) Funeral director Edwin O Wilson
(b) Address 1000 S Brantley Av.
19 (Signature of registrar) SEP 29 1944 (Date received by registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26, 1944, at 7:50P M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 11, 1944, to Sept. 26 1944, and that I last saw h. im alive on Sept. 26 1944.

Immediate cause of death Carcinoma of lung & Metastasis ? — Duration 7
Due to
Due to
Other Conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature [illegible] M. D.
Address Balt City Hosp Date signed 9-27-44

G21110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 f

G21110 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BARON RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Belvedere Ave
(c) Hospital or institution Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 34

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2628 Oswego Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Reuben Simon Cutler

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-7147

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sophie -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business

FATHER 12. Name

13. Birthplace Russia

MOTHER 14. Maiden Name -

15. Birthplace Russia

16 (a) Informant Sophie Cutler

(b) Address 2628 Oswego Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)

(c) Cemetery or crematory Windsor Hill Rd

Location

18 (a) Funeral director Jos Levine Inc

(b) Address 1439 E Balto St

19 (Date received) SEP 28 1944 Huntington Williams M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1944, at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1944, to 9-26 1944, and that I last saw him alive on 9-26 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of liver	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Myron J. Myers M. D.

Address Sinai Hospital Date signed 9-26-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G 21111

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No. G 21111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: SINAI HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1128 FORREST ST (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MILTON I. MILLER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	DIVORCED

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 11, 1887

8. AGE: Years	Months	Days	If less than one day
57	3	15	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business NEWS-POST

FATHER
12. Name RICHARD A. MILLER
13. Birthplace BALTIMORE, MD.

MOTHER
14. Maiden Name SOPHIA WALLER
15. Birthplace BALTIMORE, MD.

16 (a) Informant RICHARD A. MILLER, JR.
(b) Address 111 N. CHARLES ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3501 Frederick Rd.

18 (a) Funeral director William J. Tickner
(b) Address North and Penna. Ave.

19 (a) 9/28/44 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1944, at 6:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1944, to 9-26 1944, and that I last saw him alive on 9-26 1944.

Immediate cause of death Pulmonary edema

Due to Thrombosis Aortic

Due to Psoas abscess

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Pulmonary edema; psoas abscess

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman J. Myers M. D.
Address Sinai Hospital Date signed 12-6-44

G21112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ G21112 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the correct age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 2015
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 324 S. Smallwood St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nick Sackel

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Married

6 (b) Name of husband or wife Nellie Sackel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1886

8. AGE: Years	Months	Days	If less than one day
58	6	22	hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired Proprietor
11. Industry or business Lunch Room

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs. Nellie Sackel
(b) Address 324 S. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1944 to 9-27 1944, and that I last saw h/m alive on 9-26 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Arterial Hypertension	
Due to	
Other Conditions Diab. mellitus, chronic nephritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Rang M. D.
Address Univ. Hosp. Date signed 9-27

G21113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93N

Registered No. G21113

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 843 Glenwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1618 Elmtree St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Mullauer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Fred Mullauer

6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) , 1878

8. AGE: Years 66 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Austria (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Hudlicka

FATHER 13. Birthplace Austria

MOTHER 14. Maiden Name Unknown

MOTHER 15. Birthplace Unknown

16 (a) Informant Mrs. Cecelia Martelle

(b) Address 843 Glenwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)

(c) Cemetery or crematory Holy Cross

Location Anne Arundel Co.

18 (a) Funeral director Carl L. Hess

(b) Address 715 Light St.

SEP 28 1944 (Date received by registrar) (b) Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 26th 1944, at 11 25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 13 1944 to Sept. 26 1944, and that I last saw her alive on Sept. 24 1944.

Immediate cause of death: Arteriosclerosis Cardio-vascular Renal

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Wm Helmuth M. D.

Address 701 N. Howard St. Date signed 9/28/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21114

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

932

G21114 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2039 ROBB ST.
(c) Hospital or institution:

918

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2039 ROBB ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SYLVANUS HAND

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOWER
6 (b) Name of husband or wife: LIVINIA HAND
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): SEPT 30 1859

8. AGE: Years 84 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace: LONG ISLAND NEW YORK (Town, county, and state)
10. Usual Occupation: MOTORMAN
11. Industry or business: BALTO.TRANS.CO.

FATHER
12. Name: HAND
13. Birthplace: N.Y.

MOTHER
14. Maiden Name: VELA GANN
15. Birthplace: N.Y.

16 (a) Informant: LOUISE COPPER (DAUGHTER)
(b) Address: 1407 CLIFTVIEW AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT 29/44 (month) (day) (year)
(c) Cemetery or crematory: OAK LAWN
Location: EASTERN AVE.EXT.

18 (a) Funeral director: Lilly and Zeiler INC.
(b) Address: 403 S.WOLFE ST.

19 (a) (Date received by registrar) (b) Registrar

VS II SEP 28 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT.25 1944 at 11/45 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to Sept 25 19 44, and that I last saw h. alive on Sept 21 19 44

Immediate cause of death: Chr. Myocarditis

	Duration
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Joseph Lowery M.D.
Address 4611 S. Ellwood Ave Date signed 9/27/44

G21115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

56 aG21115

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 S. DEAN ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 S. DEAN ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE COTTER

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: FEMALE

5. Color or race: WHITE

6 (a) Single, married, widowed, or divorced: SINGLE

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 10 1898

8. AGE: Years 45 | Months 11 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual Occupation HOUSE WORK

11. Industry or business AT HOME

FATHER
12. Name PATRICK COTTER
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name MARY BEHR
15. Birthplace BALTO. MD.

16 (a) Informant ANNA HEIMBACH (SISTER)
(b) Address 708 S. BAYLIS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof SEPT. 29/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) ... (b) ... Registrar
(Date rec'd by registrar) SEP 28 1944 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 26 1944 at 6 AM PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-6 1944 to 9-26 1944, and that I last saw h alive on 9-25 1944.

Immediate cause of death: Cyst adenoma of Left ovary — pseudo-Rheimous — Duration: 6 months

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation 4-6-44

Major findings of operation: See cause of death

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Dondon M. D.

Address 321 S Eastern ave Date signed 9-28-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X G21116

131a

Registered No.

1. PLACE OF DEATH: Fran
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-6-44 9-26-44
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Glyndon/Worthington Valley (If outside city or town limits, write RURAL and give town)
(d) Street No. none (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elsie Hale Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. M.

6 (b) Name of husband or wife Raymond C. Brown

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) March 12-1904

8. AGE: Years 40 | Months 6 | Days 14 | If less than one day — hr. — min.

9. Birthplace White House Balto Co - Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business none

FATHER
12. Name Timothy Stanley Hall
13. Birthplace White House Balto Co - Md.

MOTHER
14. Maiden Name Hester Bartlett
15. Birthplace Beckleysville Md.

16 (a) Informant Raymond C. Brown
(b) Address Glyndon Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29-1944 (month) (day) (year)
(c) Cemetery or crematory Asbury Cemetery
Location Reisterstown Md.

18 (a) Funeral director Unv Bergmann Sons
(b) Address Reisterstown Md.

19 (a) SEP 28 1944 Worthington Valley Md.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/26/44 19 , at 10 20 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/6/44 19 , to 9/26/44 19 , and that I last saw her alive on 9/26/44 19 .

Immediate cause of death Cardiac Failure — Duration

Due to Hypertensive C. V. Disease

Due to Chronic Glomerulonephritis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Johns Slack M. D.
Address Franklin Sq. Hosp. Date signed 9/27/44

G21117

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 1944

G21117 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A A Co
(c) City or town Severna Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anton V Carney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Olga J.
6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-1884

8. AGE: Years	Months	Days	If less than one day
60	4	21	hr. min.

9. Birthplace Austria (Town, county, and state)
10. Usual Occupation Dress Maker
11. Industry or business

FATHER
12. Name Anton —
13. Birthplace Austria

MOTHER
14. Maiden Name Dont Know
15. Birthplace

16 (a) Informant Olga V Carney
(b) Address 1429 Wash Blvd
17 (a) Cremation (b) Date thereof 9/29/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd
18 (a) Funeral director Edward Lowe
(b) Address 1359 Wash Blvd
19 (a) (b)
(Date rec'd by registrar) Registrar

SEP 28 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1944, at 5-40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944 to Sept 26 1944, and that I last saw h[illegible] alive on Sept 26 1944.

Immediate cause of death	Duration
Coronary arteriosclerosis	
Due to	
Due to	
Other Conditions Pulmonary edema	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy: Same as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul G. Lukatos M.D.
Address 1213 Light St. Date signed 9/28/44

G21118

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21118

Registered No. .....

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 447 W. 23rd Street
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Lilian Morgan

3 (b) If veteran, name war .....

3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 23. 44.

8. AGE: Years	Months	Days	If less than one day
	7	4	..... hr. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation .....

11. Industry or business .....

FATHER
12. Name Winfield S. Morgan
13. Birthplace Md.

MOTHER
14. Maiden Name Anna M. Keiffer
15. Birthplace Md.

16 (a) Informant Winfield S. Morgan
(b) Address 447 W. 23rd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/28/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Chenoweth & Donovan
(b) Address 305-17 Chestnut Ave.

19 (a) ..... (b) .....
(Date received by Registrar) Huntington Williams
Registrar

SEP 28 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27 19 44, at 9:25 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Pneumonia, Lobular.
Whooping Cough.

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature H. F. Wallhauser M.D.
Medical Examiner.

Date signed Sept. 28, 1944.

G21119 ✓ G21119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Scott Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 Reed Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Levin N. Bee

3 (b) If veteran, name war	3 (c) Social Security Account No.
–	–

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Thedelia Bee
6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) Aug. 20, 1897

8. AGE: Years	Months	Days	If less than one day
47	1	7	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation Steamfitter
11. Industry or business

FATHER
12. Name Corbin Bee
13. Birthplace Virginia

MOTHER
14. Maiden Name Roberta Jones
15. Birthplace Va

16 (a) Informant Thedelia Bee
(b) Address 703 Allegany Place

17 (a) Burial (b) Date thereof 10/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Northumberland
Location Co. Va

18 (a) Funeral director Geo. L. Kelaher
(b) Address 1303 Pennsylvania Ave

19 (a) SEP 28 1944 (b) Huntington Williamsport, Md.
(Registrar's signature)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26-1944, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Acute Pulmonary Edema

Due to

Other Conditions Hypertrophy & Acute Dilatation of Heart
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 9-27-44

G21120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21120 / 83a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1034 Stockton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 9

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1034 Stockton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Crawley Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-10-1064

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Gertrude
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace King Geo. Co, Va
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

MOTHER / FATHER

12. Name John Crawley
13. Birthplace Virginia
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Gertrude Crawley Jackson
(b) Address 1034 N. Stockton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location md

18 (a) Funeral director Mrs. H. Kelson
(b) Address 1303 Presstman St

19 (a) SEP 28 1944 (Date received by registrar) (b) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1944, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

25. Signature Robert L. Futcher M.D.
Medical Examiner.
Date signed Sept 26 1944

VS 151

185061
G21121

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

117a G21121

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Aisquith St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MacKenzie Pigford

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-3377

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife Alberta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-00

8. AGE: Years	Months	Days	If less than one day
44	4	21	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Jane Pigford
15. Birthplace N.C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30th 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md.

18 (a) Funeral director Benjamin H. Wright
(b) Address 725 Aisquith St

19 (a) (Date received by Registrar) SEP 28 1944 Huntington-Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1944 at 12:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1944 to Sept 26 1944 and that I last saw deceased alive on Sept 26 1944

Immediate cause of death Sudden respiratory failure — Duration

Due to Perforated peptic ulcer, generalized peritonitis

Due to

Other Conditions Apparent post-op. breakdown of suture line (Include pregnancy within 3 months of death)

Date of operation Sept 23

Major findings of operation: Perforated peptic ulcer 1 cm. in diameter

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred O. Thomas, M.D.
Address Johns Hopkins Hosp Date signed 9/27/44

G21122

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G21122 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 W. Pratt St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel A. Weiser

3 (b) If veteran, name war none
3 (c) Social Security Account No. 196-09-0937

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Nellie B. Weiser
6 (c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) 9/5/1911

8. AGE: Years 33 | Months 0 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Penna (Town, county, and state)

10. Usual Occupation
11. Industry or business Coal Dealer

FATHER 12. Name John Weiser
13. Birthplace Penna

MOTHER 14. Maiden Name Anna E. Baum
15. Birthplace Penna

16 (a) Informant Nellie B. Weiser
(b) Address 1313 W. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29 - 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Lebanon Penna

18 (a) Funeral director Roth C. & B. M. Walter
(b) Address Pratt & Church Sts

19 (a) ... (b) ... (Date rec'd by registrar)
SEP 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1944, at 12 27 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-27 1944 to 9-27 1944, and that I last saw h[illegible] alive on 9-27 1944.

Immediate cause of death: Chronic Nephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles P. McDonald M. D.
Address 1213 Light St Date signed 9-27-44

G21123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G21123 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1545 Northgate Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nina St. Dixon (DIXON)

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Darius McC. Dixon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May-10-1873

8. AGE: Years 71 72 | Months 4 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Hse. None

11. Industry or business None

FATHER
12. Name Ephriam Kelso
13. Birthplace Md

MOTHER
14. Maiden Name Alta Wilson
15. Birthplace Md.

16 (a) Informant Dr. D. McClelland Dixon (son)
(b) Address 1545 Northgate Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/44. (month) (day) (year)
(c) Cemetery or crematory Oakland Cemetery
Location Oakland, Maryland

18 (a) Funeral director Stewart & Mowen Company
(b) Address 108-W-North Ave. City

19 SEP 28 1944 (Date rec'd by registrar) Huntington Nettleship, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1944 to 9-27 1944. and that I last saw her alive on 9-27 1944.

Immediate cause of death: Respiratory Failure — Duration:
Due to: Carcinoma of ovary & multiple metastasis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. S. Robertson M. D.
Address Univ. Hospital Date signed 9-27-44

621124
28776

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1466 Registered No. 621124

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-3
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 50 N. Caroline St. (If rural give location)
(e) Citizen of foreign country? YES (Yes or No)
If yes, name country CHINA

3 (a) FULL NAME Thomas Lee

3 (b) If veteran, name war	3 (c) Social Security Account No.
NONE	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Yellow	WIDOWER

6 (b) Name of husband or wife Annie Lee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-30-74

8. AGE: Years	Months	Days	If less than one day
70	3	25	hr. min.

9. Birthplace China (Town, county, and state)
10. Usual Occupation Restaurant (owner)
11. Industry or business

FATHER
12. Name Frank Lee
13. Birthplace China

MOTHER
14. Maiden Name ? Yeer
15. Birthplace China

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-28-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn-Baeb. P. Rd.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 SEP 28 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25-1944, at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 6-20-1944 to 9-25-1944, and that I last saw him alive on 9-25-1944.

Immediate cause of death	Duration
Carcinoma of oesophagus	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-21-44
Major findings of operation: Carcinoma of oesophagus
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Langmire Jr. M.D.
Address Johns Hopkins Hosp. Date signed 9-25-44

G21125

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1042

Registered No. G21125

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: East Balto. Gen. Hos.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1419 Gounder Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Alice Aklin

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/17/1944

8. AGE: Years	Months	Days	If less than one day
	4	10	hr. min.

9. Birthplace Balto
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Coid Aklin
13. Birthplace S.C.

MOTHER
14. Maiden Name Martha Hutchinson
15. Birthplace S.C.

16 (a) Informant Coid Aklin
(b) Address 1419 Gounder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director James A Hayes
(b) Address 142 W Fayette St

19 (a) SEP 28 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27-1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Uter Perforation Dysentery

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 9-28-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21126 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7714 Daniel Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Grimes (William H. Grimes)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-1166

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Verna Grimes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4th 1887

8. AGE: Years	Months	Days	If less than one day
57	4	23	hr. min.

9. Birthplace Maryland (city or county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Taxicab

FATHER
12. Name Sorbin Grimes
13. Birthplace Md.

MOTHER
14. Maiden Name Adelaide Seaman
15. Birthplace W. Virginia

16 (a) Informant Mrs. Bertha V. Grimes
(b) Address 7714 Daniel Ave., Parkville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 30. 1944 (month) (day) (year)
(c) Cemetery or crematory Angel Hill Cemetery
Location Havre de Grace Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7901 Belair Road

19 (a) (Date received by registrar) (b)
SEP 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1944, at 8a M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18 1944, to 9-27 1944, and that I last saw him alive on 9-26 1944.

Immediate cause of death Respiratory failure — Duration

Due to Uremia

Due to Cancer of the prostate

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Palonsen M. D.
Address University Hospital Date signed 9-27-44

G21127

G21127

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1136

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 30 S. Carlton St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 19 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 30 S Carlton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gladeon Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1925

8. AGE: Years 19 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name William Davis
13. Birthplace Va

MOTHER
14. Maiden Name Gertrude Johnson
15. Birthplace Baltimore

16 (a) Informant Gertrude J. Davis
(b) Address 30 S. Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. Co. Md.

18 (a) Funeral director Chas. A. Alexander
(b) Address 627 N. Mount St

19 (a) SEP 28 1944 [illegible] Dr. Thomas J. Watkins, M.D.

VS-151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1944, at 2 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Wollenweber, M.D. M.D.
Medical Examiner.
Date signed 9-28-44

PRINT WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G21128
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 613 Collett St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: B | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-14-44

8. AGE: Years | Months | Days: 12 | If less than one day: hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name Roland Thomas
13. Birthplace

MOTHER
14. Maiden Name Helen Rodgers
15. Birthplace Balto, Md

16 (a) Informant Helen Rodgers
(b) Address 613 Collett St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

2198

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-26 1944, at 5 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1944, to 9-26 1944, and that I last saw her alive on 9-26 1944.

Immediate cause of death prematurity — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W D Lyon M. D.
Address University Hospital Date signed 9-26-44

G21129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G21129 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madeira & Linden
(c) Hospital or institution: Maryland Gen'l Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3106 Allendale Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country *

3 (a) FULL NAME Michael Patrick O'Connor

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: * *
6 (c) If alive, give age * years

7. Birth date of deceased (mo., day, yr.) Feb 20-1881

8. AGE: Years 63 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Marine engineer
11. Industry or business

FATHER
12. Name Michael O'Connor
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Delaney
15. Birthplace Ireland

16 (a) Informant James T. O'Connor
(b) Address Ireland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt Royal Ave

SEP 28 1944 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1944, to 9-27 1944, and that I last saw h[illegible] alive on 9-27 1944.

Immediate cause of death: Pulmonary embolism — Duration:
Due to: Pelvic thrombosis (Rt femoral)
Due to: Postoperative to Intestinal fixation
Other Conditions: Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: obstruction of sigmoid (neoplasm)
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M. D.
Address Md Gen Hosp Date signed 9-27

G21130

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G21130 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 West 29th. St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 35 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County *****
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 West 29th. St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Marge Celeste Lohmeyer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6. (b) Name of husband or wife Carl Lohmeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
About 58	?	?	hr. min.

9. Birthplace Somerset Co., Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business ******

FATHER
12. Name ? White
13. Birthplace Maryland

MOTHER
14. Maiden Name Annette Evans
15. Birthplace Maryland

16 (a) Informant Robert H. Lohmeyer
(b) Address 109 West 29th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears & Son
(b) Address 805 N. Calvert St.

19 (a) (Date rec'd by registrar) (b) Registrar

SEP 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 27th 1944, at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 28th 1927 to Sept 27 1944, and that I last saw h.e alive on July 30th 1944.

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Coronary art. sclerosis / Angina pectoris	since 1930
Due to Generalized artscl. / Hypertension	since 1927
Other Conditions Cerebral hemorrhage (Hemiplegia)	1943

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl. Date signed Sept 28 1944

M. D. B. 1268-6

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21131 G21131

CERTIFICATE OF DEATH

13 B

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 Druid Hill Ave St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Horace W. Talley

(a) Residence: No. 918 Druid Hill Ave. St., 17-1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
male	Col	[illegible]

3a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Sept 27, 1904

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39	40	11	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Wilmington, Del
(State or country)

FATHER

13. NAME Thomas H. Talley

14. BIRTHPLACE (city or town) Spartansville Co. Va
(State or country)

MOTHER

15. MAIDEN NAME Mildred Anderson

16. BIRTHPLACE (city or town) Louisville, Va
(State or country)

17. INFORMANT Florence Evans
(Address) 918 Druid Hill Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place Mt Calvary Date Sept 30. 1944

19. UNDERTAKER Va Brooks
(Address) 1423 McCaney St

20. Filed SEP 29 1944 19 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept. 26, 1944

22. I HEREBY CERTIFY, That I attended deceased from August 24, 1944 to Sept. 26, 1944

I last saw him alive on Sept. 26, 1944. Death is said to have occurred on the date stated above, at 10.15 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pulmonary Tbc.	1 yr.

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Clinical Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
No If so, specify

(Signed) W. Donald Bandy M. D.

(Address) 2445 Druid Hill Ave.

V. S. S. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G21132

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G21132 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1211 Light St.

(c) Hospital or institution: South Balto. Gen.

(d) Length of stay in hospital or inst. (yrs., mos., or days) Edna.

(e) Length of stay in Baltimore (yrs., mos., or days) 69 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Balto.

(c) City or town Balto.

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1233 Light ST.

(If rural give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country

3 (a) FULL NAME Tena Dorr

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John F. Dorr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1875

8. AGE: Years	Months	Days	If less than one day
69	4	5	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Leopold Washeufeldt

13. Birthplace Germany

MOTHER

14. Maiden Name Phillipinna ?

15. Birthplace Germany

16 (a) Informant Mr. John F. Dorr

(b) Address 1233 Light St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)

(c) Cemetery or crematory Woodlawn Cem.

Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) SEP 29 1944 (Date rec'd by Local Registrar) Huntington Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-27 1944 at 7 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1944 to 9-27 1944 and that I last saw h er alive on 9-26 1944

Immediate cause of death Cerebral Hemorrhage

Due to epilepsy following fall

Due to

Other Conditions Fracture Left Leg -

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident

(b) Date of occurrence 9-19-44 8 A M

(c) Where did injury occur? (House) Balto. Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? no -

(Specify type of place)

(e) Means of injury Fell to the floor -

23. Signature H. B. Washeufeldt MD

Address 1211 alright St Date signed 9-27-44

Approved by Howard J. Thomas, M.D.

G21133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46B

G21133 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 S. Streeper ST.
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days) 50 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Victoria Swiec

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	W

6 (b) Name of husband or wife John Swiec
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/22/1882

8. AGE: Years	Months	Days	If less than one day
62	7	6	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name FRank Kosman
13. Birthplace Poland

MOTHER
14. Maiden Name Janicka
15. Birthplace Poland

16 (a) Informant Julia Swiec
(b) Address 510 S. Streeper St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Avenue

18 (a) Funeral director John J. Duda
(b) Address 2829 Hudson St.

19 (a) SEP 29 1944 (Date received) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/44 19 at 2:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 44 to Sept 28 19 44, and that I last saw h[illegible] alive on Sept 27 19 44

Immediate cause of death	Duration
Carcinoma - gastric	1 yrs. ?
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 1941
Major findings of operation: Intestinal obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leon S. DiLeo M. D.
Address 432 N Patterson Park Date signed 9/29/44

G21134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132 Registered No. G21134

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PRINT WITH PLAIN, WITH ONE READING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Loud Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 207 W. Hamburg St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bernard Johns

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 30 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL SEP 28 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 SEP 29 1944 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1944, at 7 45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Due death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Fraker M.D. Medical Examiner.

Date signed Sept 11 1944

2200

VS 151

G21135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 169

Registered No. G21135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6510 St Helena Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MELVIN GUY THACKER

3 (b) If veteran, name war ------

3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1931

8. AGE: Years	Months	Days	If less than one day
13	8	17	hr. min.

9. Birthplace West Va. (Town, county, and state)

10. Usual Occupation Schoolboy

11. Industry or business

FATHER
12. Name James Thacker
13. Birthplace W.Va.

MOTHER
14. Maiden Name Eva Fifer
15. Birthplace W.Va.

16 (a) Informant Mr. James Thacker
(b) Address 6510 St. Helena Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge Mem. Pk.
Location Elkridge Md.

18 (a) Funeral director Philip Harvey Sons
(b) Address 2024 Orleans St.

19 (a) (registrar) (b) Huntington Wilkerson, M.D.

SEP 29 1944
VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1944, at 6 P M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushing of chest and arms

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-27-44 5 30 P M. 26/6
(b) Where did injury occur? Halsted & 5th Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Industry While at work? No
(d) Means of injury pedestrian struck by train

23. Signature H. L. Wallenmeyer M.D. Asst Medical Examiner.
Date signed 9-28-44

G21136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G21136
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 152
(c) Hospital or institution: Md. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10.0.0
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Solon ~~Solomon~~ Peter Smith

3 (b) If veteran, name war .....

3 (c) Social Security Account No. 27-05-1822

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife .....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years 35 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Balto City
(Town, county and state)

10. Usual Occupation Porter

11. Industry or business .....

FATHER
12. Name James F. Smith
13. Birthplace Va

MOTHER
14. Maiden Name Agustin Jefferson
15. Birthplace Md

16 (a) Informant Phoencia Smith
(b) Address 1306 N Bruce St

17 (a) Burial (b) Date thereof Sept 29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location .....

18 (a) Funeral director Robt L Wiley
(b) Address 715 Mc Cabe Bldg

SEP 29 1944
(Date rec'd by registrar)

(b) Huntington Nottingham, Md.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 25 1944 at 11 20 P. M.

I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound
of Chest

Due to .....

Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 26 1944 11 15 P. M.
(b) Where did injury occur? 1618 Eutaw Place
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shooting

23. Signature Robert B. Graham M.D.
Medical Examiner.
Date signed Sept. 26, 1944

G21137

G21137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital 18-9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Anison

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 yrs. | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Not known
13. Birthplace "

MOTHER
14. Maiden Name Not known
15. Birthplace "

16 (a) Informant Robert Boundley
(b) Address 931 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs Frances A. Lindsay
(b) Address 578 W. Biddle St

19 (a) (Date received by Registrar) (b) Registrar

SEP 29 1944 Huntington Williams, M. D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26/44 19 to 9/27/44 19, and that I last saw her alive on 9/27/44.

Immediate cause of death Respiratory Failure — Duration: 1 day

Due to Cerebro-Vascular Accident

Due to Hypertensive Cardio-Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Dean Paschal, M. D.

Address Univ. Hospital Date signed 9/27/44

G21138 BALTIMORE CITY HEALTH DEPARTMENT G21138

CERTIFICATE OF DEATH 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring Ave
(c) Hospital or institution: Hebrew Home for Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Hebrew Home for Aged. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT KRIEGER
3 (b) If veteran, name war
3 (c) Social Security Account No.

4 Sex M female | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W

6 (b) Name of husband or wife Poe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Capt. Renner
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Jos. Levy Sons
(b) Address 1439 E. Baltimore St.

19 (a) (Date) (b) Registrar
SEP 29 1944
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1944 at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941, to Sept 28, 1944, and that I last saw him alive on Sept. 28 1944.

Immediate cause of death Cerebral Hemorrage — Duration

Due to Arteriosclerosis cerebri

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Manny Rapf for Dr. A.S. Goldstein M. D.
Address Levindale Home Date signed Sept. 29/44

G21139

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1944

G21139 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt 15-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 N. Smallwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FIDEL BLUMBERG

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced M

6 (b) Name of husband or wife Hannah
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Presser
11. Industry or business

MOTHER / FATHER
12. Name Not Known
13. Birthplace Russia
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-29-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hwy & Hamilton Ave

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Balto St.

19 (a) SEP 29 1944 (Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1944, at 10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1944, to 9-28 1944, and that I last saw h[illegible] alive on 9-28 1944.

Immediate cause of death Coronary Thrombosis
Due to Arteriosclerotic Heart
Due to Cirrosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. D. Levitt M.D.
Address Sinai Hosp. Date signed 9-29-44

G21140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G21140 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 N. Gilmor St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N. Gilmore
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Ann Pratt

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept. 26, 1944

8. AGE: Years	Months	Days	If less than one day
—	—	2	— hr. — min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Pratt
13. Birthplace Unknown

MOTHER 14. Maiden Name Dorothy Dorsey
15. Birthplace

16 (a) Informant mother
(b) Address 108 N. Gilmor St

17 (a) Burial (b) Date thereof 9-29-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Wilson

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 730 N. Schroeder St.

SEP 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1944 to Sept 28 1944 and that I last saw h.e.r alive on Sept 27 1944

Immediate cause of death	Duration
Prematurity 3rd approximately 33 weeks	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Thurman M.D.
Address 1108 N. Broadway Date signed 9-28-44

G21141

141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √158

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 21
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 Russell St
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Norman Binns

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Mch 28-44

8. AGE: Years	Months	Days	If less than one day
	6	29	..... hr. ..... min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation .....
11. Industry or business Mine

FATHER
12. Name Arnold Woodlon
13. Birthplace Balto.

MOTHER
14. Maiden Name Dorothy Binns
15. Birthplace Balto.

16 (a) Informant Dorothy Binns
(b) Address 1106 Russell St

17 (a) Burial (b) Date thereof 9/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location .....

18 (a) Funeral director James Adams
(b) Address 1142 Ustill St

19 (a) Date received SEP 29 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1944, at 7:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1944 to 9/27 1944, and that I last saw him alive on 9/27 1944.

Immediate cause of death Malnutrition — Duration .....

Due to ..... — Duration .....

Due to ..... — Duration .....

Other Conditions ..... — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) ..... (County) ..... (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature G. L. Banfield

Address Provident Hospital Date signed 9/29/44 (M. D.)

G21142

G21142

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No.

YA-89980

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5½ hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 145 N. Montford Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wicenty William Dzimianski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jadviga

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 20, 1894

8. AGE: Years 50 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ? (d)
13. Birthplace Poland

MOTHER
14. Maiden Name ? ? (d)
15. Birthplace Poland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof Sep 30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore County

18 (a) Funeral director John M. Debey
(b) Address 408 S. Chester Street

19 (a) SEP 29 1944
(Date received by Registrar)

Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1944, at 7:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1944 to 9/27 1944, and that I last saw him alive on 9/27 1944.

Immediate cause of death: Acute cardiac failure & pul. edema.
Due to A.S.C.V.D.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration
12 hrs.

Date of operation
Major findings of operation:
of autopsy: No autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. L. Seigman M. D.
Address B<H Date signed 9/27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1243

Registered No. G21143

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 747 W. Franklin St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 747 W. Franklin St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harper Matthews

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Married

6 (b) Name of husband or wife Bessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1881

8. AGE: Years	Months	Days	If less than one day
63	6	24	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer Unemployed
11. Industry or business

FATHER
12. Name Dennis Matthews
13. Birthplace Va.

MOTHER
14. Maiden Name Susan Laires
15. Birthplace Va.

16 (a) Informant Bessie Matthews
(b) Address 747 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 1-1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus M. Park
Location Arbutus Md.

18 (a) Funeral director Mrs. Robert O. Ellis & Son
(b) Address 1129 N. Eutaw St.

SEP 29 1944 (Date received by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19-44 19 to 9-28 19 44 and that I last saw h[illegible] alive on 9-28 19 44

Duration
9 mos.
1 mo.

Immediate cause of death
Cerebral Embolism
Due to Myocarditis
Due to Indefinite
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jas. R. Bleke M. D.
Address 1327 N. Central Date signed 9/28/44

G21144

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinia Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 532 N. Curley St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Madeline C. Smallwood

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife Owen M.
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Dec 18 1919

8. AGE: Years	Months	Days	If less than one day
24	9	9	hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Office Work
11. Industry or business Western Electric Co

FATHER
12. Name Frank Hasbeck
13. Birthplace Balto

MOTHER
14. Maiden Name Madaline Roth
15. Birthplace Balto

16 (a) Informant Owen M. Smallwood Sr
(b) Address 532 N. Curley St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Mart A.B. Reppolis
(b) Address 37 S. Jonas St.

SEP 29 1944 (Date received by Local Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27, 1944, at 1.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Sept 27 1944, and that I last saw her alive on Sept 22 1944

Immediate cause of death	Duration
Basalar Meningitis	
Due to Meningococcus Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Basalar Meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome A Durkin M. D.
Address Sinai Hosp. Date signed

G21145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 93D

Registered No. G21145

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N Arlington Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Washington
(c) City or town Hagerstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 665 Forest Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen N. Young

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Moses Young
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1878

8. AGE: Years	Months	Days	If less than one day
66	8		hr. min.

9. Birthplace Hagerstown Md
(Town, county, and state)
10. Usual Occupation Cook
11. Industry or business

FATHER
12. Name Henry F. Kee
13. Birthplace Md

MOTHER
14. Maiden Name Ellen A. Dorsey
15. Birthplace Md

16 (a) Informant Nana Faulk
(b) Address 506 N Arlington Ave

17 (a) Burial (b) Date thereof 9 28 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cem
Location Hagerstown Md

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

Sept 29 1944 Mrs Katie R Williams M.D.
(Date received) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1944 at 12:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1944 to 9-28 1944 and that I last saw h[illegible] alive on 9-28 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	1 yr
Due to Cardio Vascular Disease	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature W. Atwell Jones M. D.
Address 55 Y Dolphin St Date signed 9-28-44

G21146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

Registered No. G21146

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga
(c) Hospital or institution:
Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d 15
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2428 Eutaw place
(If rural give location)
(e) Citizen of foreign country? , (Yes or No)
If yes, name country

3 (a) FULL NAME Emil Bartsch

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Katherine Bartsch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10-1878

8. AGE: Years	Months	Days	If less than one day
66 70	3	18	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Newsboy
11. Industry or business

FATHER
12. Name Carl J Bartsch
13. Birthplace Germany

MOTHER
14. Maiden Name Ernst
15. Birthplace

16 (a) Informant Ernest C Bartsch
(b) Address 2428 Eutaw Place

17 (a) Burial (b) Date thereof Sept 30-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore Md

18 (a) Funeral director Manuel Cook Byer
(b) Address 1600 W North Ave

19 (a) Date of death (month) (day) (year) SEP 29 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1944, at 5 35 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1944 to Sept 29 1944, and that I last saw him alive on Sept 28 1944.

Immediate cause of death	Duration
Congestive heart failure	
Due to Degenerative (arteriosclerotic) cardio vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. R. Smythe

Address Date signed 9/29/44

(over)

G21147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

V G21147

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 W. Lanvale St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Cochran

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) — 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Freeze Tindell
(b) Address 600 W. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/29/44 (month) (day) (year)
(c) Cemetery or crematory Druid Calvert
Location

18 (a) Funeral director Elroy Wilson
(b) Address 1000 Brantley Ave

19 SEP 29 1944 (b) Huntington Woods, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Pres death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed 9-29-44

VS 151

PRESS WELL FRIENDS, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21148

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21148 Registered No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item ✱ information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanover Road
(c) Hospital or institution: Bay View Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Spring St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Sodawski or Sadowski

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/14/1942

8. AGE: Years 2 | Months 2 | Days 24/14 | If less than one day hr. min.

9. Birthplace Baltimore, Md (town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER 12. Name Joe Sodawski
13. Birthplace ?

MOTHER 14. Maiden Name Martha ?
15. Birthplace ?

16 (a) Informant Father
(b) Address 111 S. Spring St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29 44 (month) (day) (year)
(c) Cemetery or crematory St Andrew Russian
Location Stoney Run a.g. County

18 (a) Funeral director John J. Grabbauskas Jr
(b) Address 423 S. Paca St

19 (a) (Date received by registrar) SEP 29 1944 (b) Huntington Hillsborough Sydenham Hosp

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28/44, at 11:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20/44, to 9/28 19 44, and that I last saw h— alive on 9/28 19 44.

Immediate cause of death Cardiac failure — Duration

Due to Diphtheria — Myocarditis — 10 Days

Due to Diphtheria

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9/20/44
Major findings of operation: Membranous, Pseudomembranous ulcers
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret K. D. Smith M. D.
Date signed 9-29

G21149 ✓ G21149

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline Street
(c) Hospital or institution:
Saint Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7429 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August M. Di Domenico

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1930

8. AGE: Years	Months	Days	If less than one day
14	5	6	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name Samuel Di Domenico
13. Birthplace Italy

MOTHER
14. Maiden Name Margaret Brennan
15. Birthplace Baltimore

16 (a) Informant Mr. Samuel Di Domenico
(b) Address 7429 Harford Road, #14

17 (a) Burial (b) Date thereof 10/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) (b)
(Filled by registrar) Registrar

SEP 29 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1944, at 10:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1944, to 9/28 1944, and that I last saw him alive on 9/18 1944

Immediate cause of death	Duration
Cardiac failure	
Due to Rheumatic Carditis Chron.	
Due to	
Other Conditions Decompensation Pulmonary oedema (Include pregnancy within 3 months of death)	

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nelson J. Samonka M.D.
Address 4 E Lexington St Date signed 9/29/44

G21150

BALTIMORE CITY HEALTH DEPARTMENT G21150 Registered No.

CERTIFICATE OF DEATH 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1813 N. Regester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 N. Regester St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Aloysius Frank Goedeke

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth M.
6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) April 24-1869

8. AGE: Years	Months	Days	If less than one day
75	5	5	hr. min.

9. Birthplace Baltimore - Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Lorenz F. Goedeke
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant L. Frank Goedeke
(b) Address 1813 N. Register St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd.

19 (a) SEP 29 1944 (Date received by Registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29th 1944 at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940, to Sept 28 1944, and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Chronic Cardio Vascular Disease	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Ayd M. D.
Address 2005 E. Monument St Date signed 9/29/44

Huntington Williams, MD

G21151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21151 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Agnes Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D. C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years	Months	Days	If less than one day
60			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1944 (month) (day) (year)
(c) Cemetery or crematory Soldiers Home
Location National Cemy. Wash D.C.

18 (a) Funeral director Stanley James
(b) Address Soldiers Home, Wash. D.C.

19 (a) SEP 29 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

45

20. DATE OF DEATH Sept 28 1944 at 10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 29 1944

G21152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21152 Registered No. 95c

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4519 Wilmslow Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4519 Wilmslow Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Millard P. Leese.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 717-07-6215

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Lydia A. Leese (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Jan 23, 1887

8. AGE: Years	Months	Days	If less than one day
57	8	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Signalman
11. Industry or business Penna R.R.

FATHER 12. Name Robert H. Leese
13. Birthplace Pa.

MOTHER 14. Maiden Name Alice Koch.
15. Birthplace Maryland

16 (a) Informant Lydia A. Leese
(b) Address 4519 Wilmslow Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/44 (month) (day) (year)
(c) Cemetery or ~~cemetery~~ Woodlawn.
Location

18 (a) Funeral director Chenowith & Donovan
(b) Address 3615-17 Chestnut Ave

19 (a) (b) Huntington, Williamsport, Md.

SEP 29 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28, 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5 1920 to Sept 28 1944, and that I last saw him alive on Sept 28 1944.

Immediate cause of death Pulmonary Edema — Duration few hours

Due to Congestive Heart Failure — Duration months

Due to Carcinoma Enlargement — Duration —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Simon F. T. Marlene M. D.
Address 94 W. 32nd St Date signed 9-29-44

G21153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21153
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Fleet Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 229 N. Wolfe Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Eckstein

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17 1868

8. AGE: Years 76 | Months 6 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name George Eckstein
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Steiner
15. Birthplace Maryland

16 (a) Informant Mary Baird
(b) Address 229 N. Wolfe Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30/44 (month) (day) (year)

(c) Cemetery or crematory Balto. Cem.
Location North Ave. & Gay St.

18 (a) Funeral director John G. McGee
(b) Address 2334 Jefferson St. Huntingtown Md.

19 (a) SEP 29 1944 (Date received by registrar) Huntingtown Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1944, at 2:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

Signature Howard J. Moscario M.D.
Medical Examiner.

Date signed September 28, 1944

G21154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G21154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1732 Clarkson ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1732 Clarkson ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel E. Grove

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-30-7359

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E. Grove
6 (c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): July 13, 1870

8. AGE: Years 74 | Months 2 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace: Howard Co Md (Town, county, and state)

10. Usual Occupation: Stationary Engineer
11. Industry or business: Bethlehem Fairfield Shipyard

FATHER
12. Name: Samuel E. Grove
13. Birthplace: Md

MOTHER
14. Maiden Name: Ruth Mercer
15. Birthplace: Md

16 (a) Informant: Mary E. Grove
(b) Address: 1732 Clarkson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept 30, 1944 (month) (day) (year)
(c) Cemetery or crematory: Pine Grove
Location: Md Olney Md

18 (a) Funeral director: A. Howard Evans
(b) Address: 1400 N Charles St

19 (a) SEP 29 1944 (Date received by Local Registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27, 1944 at 2.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 25 1944 to Sept 27 1944, and that I last saw ... alive on Sept 27, 1944.

Immediate cause of death: Acute dilatation of Heart — Duration: 2 hr.
Due to: Mitral regurgitation — Indefinite
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: R. L. Campbell M. D.
Address: 1644 Hanover Date signed: 9/28/44

G21155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G21155 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital of inst. (yrs., mos., or days) 5 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 W. Redwood St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Stromey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 29 1944 Commissioner of Health

18 (a) Funeral director
(b) Address

19 (a) SEP 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 14, 1944, at 5:40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture 7 pelvis; Fracture of leg, right & multiple Fractures of ribs, left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 4-2 11:30 P.
(a) Date of injury September 13 1944 M.
(b) Where did injury occur? Baltimore & Pine Sts
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert L. Gerstell M.D. Medical Examiner.
Date signed Sept. 14, 1944

F2204

VS 151

correct age is especially important. Physicians: please write the ... every item of information should be carefully supplied. ... CAUSES, AND OPERATIONS ... the causes of death clearly and legibly.

G21156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X V 46a

Registered No. G21156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Months 11 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Havre de Grace
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Rhode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace (Town, county, and State)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Richard Unknown.
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [redacted] SEP 29 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 SEP 29 1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-14 1944 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-2 1944 to 9-14 1944; and that I last saw him alive on 9-14 1944

Immediate cause of death Cardiac failure and ca. of Oesophagus & Lungs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca. of Oesophagus & Lungs

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Gutelius M.D.
Address Redwood & Greene Date signed 9/19/44

F 2203

G21157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21157 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Richmond & Ernest 3
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Flatimm Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernest Lambert

3 (b) If veteran, name war W
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife Edith B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1899

8. AGE: Years 45 | Months | Days | If less than one day hr. min.

9. Birthplace Franklin W. Va. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Wilbert Lambert
13. Birthplace W. Va.

MOTHER
14. Maiden Name Nancy Hartman
15. Birthplace W. Va.

16 (a) Informant Mrs. Edith B. Lambert
(b) Address 917 Flatimm Ave

17 (a) Removal (b) Date thereof 9/29/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Upper Grove
Location Upper Tract W. Va.

18 (a) Funeral director Tillman Funeral Home
(b) Address 1214 N. Paul St.

19 (a) (date received) (b) Registrar

SEP 29 1944 Huntington, W. Va.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1944, at 10.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 - 1944, to 9-28 1944, and that I last saw h/ alive on 9-28 1944.

Immediate cause of death	Duration
Respiratory paralysis	5 m.
Due to Brain abscess	2 wks.
Due to Pulmonary abscess	4 wks.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Range M. D.
Address Univ. Hosp. Date signed 9-28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21158 ✓ G21158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 210 S Clinton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 S Clinton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary R. Mullaney

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Wm M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 28 1883

8. AGE: Years	Months	Days	If less than one day
61	7	30	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John W. McGrail
13. Birthplace

MOTHER
14. Maiden Name Laura V. Meeks
15. Birthplace Md

16 (a) Informant Mary M. Gambrill
(b) Address 64 Kilpatrick Rd Dundalk Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1944 (month) (day) (year)
(c) Cemetery or crematory Oakleaves Cem
Location

18 (a) Funeral director Pratt C. B. & M Walter
(b) Address Pratt & Fletcher Sts

19 (a) SEP 29 1944 Huntington Williams, M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27th 1944, at 9 58 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23-44 19 , to 9-27-1944 , and that I last saw her alive on 9-27-1944 .

Immediate cause of death Cerebral Hemorrhage — Duration 4 days.

Due to Hypertension

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John Costantini, M.D.

Address 237 S. Bowling St Date signed 9-26-44

G21159 Sept 27-1944

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21159

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2048 Robb St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2048 Robb St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick McCullough Lavin

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83	—	—	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Officer

11. Industry or business

FATHER
12. Name Robert McCullough Lavin
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Timms
15. Birthplace Smithfield Maryland

16 (a) Informant Mrs Catherine McCullough Lavin
(b) Address 2048 Robb St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location

18 (a) Funeral director Mary M Wedefred
(b) Address 501 E. 22nd St

19 (a) SEP 29 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1939, to Sept 27 1944, and that I last saw h. living on Sept 26 1944

Immediate cause of death	Duration
Coronary Thrombosis	
Uremia	
Due to Coronary Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation?

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B V Kelly M. D.
Address 100 N Linwood Ave Date signed Sept 29 44

461289 G21160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21160 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 825 E. Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F. McCoy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-14-98?

8. AGE: Years	Months	Days	If less than one day
46	5	11	hr. min.

9. Birthplace Neb. (Town, county, and state)
10. Usual Occupation Hotel Manager
11. Industry or business

FATHER
12. Name Earnest McCoy.
13. Birthplace Iowa.

MOTHER
14. Maiden Name Carrie Blanchard
15. Birthplace Vermont

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct 2, 44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cemetery
Location Long Green, Md.

18 (a) Funeral director James T. Ryan Inc
(b) Address 617-21 Park Ave. Balto

SEP 29 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1944, at 4.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 24 1944, to Sept. 29 1944, and that I last saw him alive on Sept. 21 1944

Immediate cause of death	Duration
Heart Failure	10 days
Due to Rheumatic Heart Disease	4 mo
Due to	
Other Conditions Cirrhosis of liver	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at AM
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Louis Dublin M.D.
Address Johns Hopkins Date signed 9/29

G21161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

116

G21161
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10days
(e) Length of stay in Baltimore (yrs., mos., or days) 28yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 W 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hicks

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 5/9/1902

8. AGE: Years	Months	Days	If less than one day
42	4	20	hr. min.

9. Birthplace Georgia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name George Hicks
13. Birthplace Georgia

MOTHER
14. Maiden Name Sarah Calhoun
15. Birthplace South Carolina

16 (a) Informant Mary McClellan
(b) Address 211 West 23 St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Lawn Cemetery
Location Sparrows Point Md
18 (a) Funeral director Robert E Miller
(b) Address 1515 McCulloh St

19 (a) (b)
Date received by Local Registrar
SEP 29 1944
Registrar
Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29 1944, at 12 03 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/9 1944, to 9/29 1944, and that I last saw h.im alive on 9/9 1944

Immediate cause of death	Duration
Pneumonia,	
Whole right lung.	
Due to Postoperative Complication	
Due to cachexia & malnutrition	4 mo.
Other Conditions Cardiospasm & Stricture esophagus.	

(Include pregnancy within 3 months of death)
Date of operation 9/26/44
Major findings of operation: Atrophic Stomach, Stricture esophagus,
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Patrick C Phelan jr. M. D.
Address Mercy Hospital Date signed 9/29/44

G21162

BALTIMORE CITY HEALTH DEPARTMENT X V

CERTIFICATE OF DEATH 83a

Registered No. G21162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1015 N. Kenwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 Da

2. USUAL RESIDENCE OF DECEASED:
(a) State Ill (b) County
(c) City or town Chicago (If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 Harding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ALICE ROSE MITTEN

3 (b) If veteran, name war: no
3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John C. Mitten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24, 1876

8. AGE: Years 68 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Huntington, Ind. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name John Murray
13. Birthplace Ireland

MOTHER
14. Maiden Name Elizabeth Boyle
15. Birthplace Ind.

16 (a) Informant Mrs. Mildred M. Burke
(b) Address 148 N. Mayfield Ave. Chicago

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Chicago, Ill

18 (a) Funeral director Henry Sander & Sons, Inc.
Address 6th Ave. & Broadway

19 SEP 30 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION 4.15 A.M.

20. DATE OF DEATH Sept 29 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/19/44 19 , to 9/29/44 19 , and that I last saw h alive on 9/29/44 19 .

Immediate cause of death Apoplexy — Duration 8 hr.
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Alf. L. Gage M. D.
Address 708 N Broadway Date signed 9-29-44

G21163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G21163

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months: 3 | Days | If less than one day: hr. min.

9. Birthplace 618 Baker St. Balto, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Hamilton
13. Birthplace Prince Geo. Co. Md

MOTHER
14. Maiden Name Martha Hamilton
15. Birthplace Md.

16 (a) Informant Martha Hamilton
(b) Address 618 Baker St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles R. Lauer
(b) Address 802 Madison Ave

19 (a) SEP 30 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1944, at M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute Interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Sept 29 1944

G21184
S29995

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH
137a

G21164
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Turners Station
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sollers Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William H. Keene

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-7-75

8. AGE: Years 69 | Months 5 | Days 19 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Henry E. Keene
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Foster
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

SEP 30 1944
(Date received by registrar)

(a) Filed for Williams Hall
(Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1944 at 5-15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 20 1944 to Sept 26 1944 and that I last saw him alive on Sept 26 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	Immediate
Due to: Arteriosclerosis	Years
Due to:	
Other Conditions: Benign Prostatic Hypertrophy (Include pregnancy within 3 months of death)	Years

Date of operation 8/30/44
Major findings of operation: Benign Prostatic Hypertrophy
of autopsy: None Obtained.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Alan C. Woods Jr.
Address Johns Hopkins Hospital Date signed 9/29/44

G21165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G21165

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½ mon.
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ mon.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 417 W. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country NU

3 (a) FULL NAME Baby Eggleston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-44

8. AGE: Years	Months	Days	If less than one day
	2	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Mary Eggleston
13. Birthplace Florence S.C.

MOTHER
14. Maiden Name Mary Davis
15. Birthplace Florence S.C.

16 (a) Informant Mary Eggleston
(b) Address 417 W. Biddle St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL SEP 29 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) SEP 30 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-24 1944, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6 1944, to 9-24 1944, and that I last saw he/she alive on 9-24 1944.

Immediate cause of death: Acute Aspiration Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. H. Butler M.D.
Address 1033 Druid Hill Ave. Date signed 9/27/44

VS 150

2205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21166 Registered No.

JO 609297

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3725 Fait Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Kimmerle

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 216-03-3933

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1897

8. AGE: Years 46 | Months 11 | Days -7- | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name Charles Kimmerle
13. Birthplace Maryland

MOTHER
14. Maiden Name Barbara Krappel
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 2/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD.

18 (a) Funeral director Lillyand Zeiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) SEP 30 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1944, at 8:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 1944 to 9/28 1944; and that I last saw him alive on 9/28 1944

Immediate cause of death: Acute dilatation of the ventricles; myocarditis; pathological term of misery,

Duration: 24 hr.

Due to: Advanced Cancer of the rectum

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation: No Mets; enlarged spleen

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. L. Seigman M.D.
Address BCH Date signed 9/28

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21167 (Registered No.) 93D

G21167

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 505 S. WOLFE ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 → 3
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 505 S. WOLFE ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROZALIA SZCZULBLEWSKI

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife FRANK SZCZULBLEWSKI
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 1 1865

8. AGE: Years	Months	Days	If less than one day
79	0	28	hr. min.

9. Birthplace POLAND (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name
13. Birthplace POLAND

MOTHER
14. Maiden Name JOSEPHINE ZINGER
15. Birthplace POLAND

16 (a) Informant FRANK SZCZULBLEWSKI (SON)
(b) Address 505 S. WOLFE ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 3/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART OF MARY
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeiler Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date received) SEP 30 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 29 1944, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1944 to Sept 29 1944 and that I last saw h. alive on Sept 29 1944.

Immediate cause of death	Duration
CORONARY THROMBOSIS	2 DAYS
Due to ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE	??
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph F. Ochoza M. D.
Address 207 N. Chester St Date signed 9/29/44

Huntington Williams, M.D.

G21168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21168 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5033 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5033 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine L. Lawrence

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Thomas J. Lawrence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/1881

8. AGE: Years	Months	Days	If less than one day
63	2	24	hr. min.

9. Birthplace Prince George Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Robert Seabrom
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. Thomas J Lawrence
(b) Address 5033 Reisterstown

17 (a) Burial (b) Date thereof Oct 2 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cems
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Trickner & Son
(b) Address Balto, Md.

19 (a) SEP 30 1944 Huntington Williams, M.D.
(b) Date rec'd by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1944, at 9 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 29 1944

G21169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G21169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1906 McKean Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1906 McKean Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. ELLIOTT

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Joseph T.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1875

8. AGE: Years	Months	Days	If less than one day
69	2	19	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Tress
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Christina Knox
15. Birthplace Dublin, Ireland

16 (a) Informant Mr. J. Douglas Elliott
(b) Address 1906 McKean Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/2/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

SEP 30 1944 (Date rec'd by registrar) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Sept. 28, 1944, at 3:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1944 to Sept. 28 1944, and that I last saw her alive on Sept. 27 1944.

Immediate cause of death	Duration
Cerebral hemorrhage & Left hemiplegia.	8 days
Due to Arteriosclerosis	10 yrs
Due to	
Other Conditions Chronic Arthritis & Myocarditis. (Include pregnancy within 3 months of death)	10 yrs

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward J. Siegawald M. D.
Address 1613 E. North Ave. Date signed

G21170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registered No. G21170

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 & Calvert
(c) Hospital or institution: Union Mem'l Hosp 27-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1/2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3708 Hamilton Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN LUTHER VAN CLEAF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	wid

6 (b) Name of husband or wife Effie E. Van Cleaf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 3rd 1874

8. AGE: Years	Months	Days	If less than one day
69	9	25	[redacted] min.

9. Birthplace New Jersey (Town, county and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Effie Van Cleaf
(b) Address Same

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2nd 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore, Maryland

18 (a) Funeral director Lasagna Funeral Home
(b) Address 7401 Belair Road

SEP 30 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 28 Sept 1944 at 6 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 28 Sept 1944 to 28 Sept 1944, and that I last saw h[illegible] alive on 28 Sept 1944.

Immediate cause of death Respiratory failure

Due to Subarachnoid Hemorrhage

Due to Hypertension Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Conrad E. Bamfield
Address Union Memorial Hosp Date signed 9/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21171 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 West Conway St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 609 West Conway St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Amelia Newton Banks

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 11, 1871

8. AGE: Years 73 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace West River Anne Arundel maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name James H. Holland
13. Birthplace West River Anne Arundel md

MOTHER 14. Maiden Name Watkins
15. Birthplace Virginia

16 (a) Informant Ella Brooks
(b) Address 609 West Conway st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Auburn
Location Baltimore City

18 (a) Funeral director Joseph F. Lively
(b) Address 1 South Mount Street

19 (a) (Filed by registrar) (b) Registrar

OCT 30 1944 Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Septr 28 1944 at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/30 1944 to 9/28 1944 and that I last saw him alive on 9/27/1944

Immediate cause of death Chronic Myocarditis — Duration

Due to Hypertension & — Duration

Due to Arteriosclerosis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. F. Howell M. D.
Address 601 N Carrollton Ave Signed 9/29/1944

G21172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

HANN 93E G21172 Registered No.

Rooms - 1311 N. Fulton Ave

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Tenn. (b) County —
(c) City or town Whitesburg (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barnett E. Haun

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 8. 23

8. AGE: Years	Months	Days	If less than one day
20	9	21	hr. min.

9. Birthplace Tenn. (Town, county and state)
10. Usual Occupation Electrician.
11. Industry or business U S Coast Guard.

FATHER
12. Name Thomas Haun
13. Birthplace Tenn

MOTHER
14. Maiden Name Lenna Parrish
15. Birthplace Tenn.

16 (a) Informant Thomas Haun.
(b) Address Whitesburg Tenn.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-44 (month) (day) (year)
(c) Cemetery or crematory
Location Whitesburg Tenn.

18 (a) Funeral director A. Rex Odes.
(b) Address 4644 York Rd.

19 (a) SEP 30 1944 (Date received by registrar) Hamrington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29- 1944, at 12 30 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH

Acute Congestive Cardiac Failure

Due to

Other Conditions Acute gastro-enteritis

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed 9-29-44

G21173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G21173

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 507 N. Stricker
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-1
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 N Stricker (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Mills

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Ellington S. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace S. C. ?

16 (a) Informant Fannie
(b) Address 507 N. Stricker St.

17 (a) Burial (b) Date thereof 10-2-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 913 Druid Hill Ave

19 (a) SEP 30 1944 (Date received by Registrar) Washington [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1944 at 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1944 to Sept 27 1944, and that I last saw h[illegible] alive on Sept 27 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Date signed Sept 29 1944

G21174 G21174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORIES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green sts
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 619 main st. Reisterstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 main st. (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Carl Randall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, ~~widowed, or divorced~~.

6 (b) Name of husband or wife Sarah Ethel Randall
6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years 47 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Kirkersville Ohio (Town, county, and state)

10. Usual Occupation Auto. mechanic

11. Industry or business –

FATHER
12. Name John M. Randall
13. Birthplace Ohio

MOTHER
14. Maiden Name Louise Schad
15. Birthplace Ohio

16 (a) Informant Mrs. Sophia Randall
(b) Address Reisterstown, md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2-1944 (month) (day) (year)
(c) Cemetery or crematory Asbury
Location Reisterstown

18 (a) Funeral director Wm. Berryman & Sons
(b) Address Reisterstown, md.

19 (a) Date received SEP 30 1944 Huntington Williams, M.D. Registrar

VS-198

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 1944, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1944, to 9-24 1944, and that I last saw h/M alive on 9-23 1944

Immediate cause of death	Duration
Spontaneous sub-arachnoid hemorrhage	5 wks.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. J. Range M. D.
Address Mutual Hosp. Date signed 9-28

Hurley

G21175

G21175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2623 Wilkins Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2623 Wilkins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ave Hurley

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No. 219-16-5627

4. Sex: male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Sadie E. Hurley
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) January 7-1895

8. AGE: Years 51 | Months 9 | Days 21 | If less than one day: hr. min.

9. Birthplace Richmond Washington D.C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name James A. Hurley
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Doran
15. Birthplace Md.

16 (a) Informant Mrs Sadie E. Hurley
(b) Address 2623 Wilkins Ave

17 (a) Burial (b) Date thereof 10/20/46
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director F.B. Wagner & Son
(b) Address 1300 Eutaw Place

19 (a) (Registrar's signature) Hunter Williams

SEP 30 1946

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28th 1946 at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 29 1946 to Sept 28 1946 and that I last saw him alive on Sept 27 1946.

Immediate cause of death: Carcinoma of Colon — Duration: 1 Year
Due to:
Due to:
Other Conditions: Cardiovascular Disease & Hypertension — 3 Years
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eliot W. Johnson M. D.
Address 3652 Juneau Ave Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

632a

Registered No. G21176

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Sweeney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Wm. J. Sweeney

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22 1873

8. AGE: Years	Months	Days	If less than one day
70 71	10	6	hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm. J. Sweeney
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Catherine Stallings
15. Birthplace Balto. Md.

16 (a) Informant Raymond J. Sweeney
(b) Address 2684 Dukeryde

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director J. B. Happersett & Son
(b) Address 300 Eutaw Place

19 (a) SEP 30 1944 (b) (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28th 1944, at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1940, to Sept 28 1944, and that I last saw h[illegible] alive on Sept. 27 19 44.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Hypertension	?
Due to Generalized arteriosclerosis.	?
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. D. Schneider M. D.
Address 54 S. Fulton Ave Date signed 9-27-44

Assistant Williams, M.D.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21177 (1938) — Registered No. G21177

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 N. Eutaw St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1085 Elliott Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

16-7

3 (a) FULL NAME Martha M. Davis

3 (b) If married, name wife — | 3 (c) Social Security Account No.

4 Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Chas. W. Davis | 6 (c) If alive, give age years

7. Birthdate of deceased (mo., day, yr.) February 16 1875

8. Age: 69 years | Months 7 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Kind of business or business

FATHER: 12. Name Emory J. Dennis | 13. Birthplace Md

MOTHER: 14. Maiden Name Mary E. Belt | 15. Birthplace Md

16. Informant Mrs. R. L. Lemmon | Address 1 N. Eutaw St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Baltimore, Md.

18 (a) Funeral director F. B. Shipley & Son

(b) Address 1300 Eutaw Place

19. Filed 9/30/1944 Received by (signature) Thos. Livingston for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/27/ 1944 at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944 to Sept. 27 1944, and that I last saw her alive on 9/27 1944.

Immediate cause of death: arteriosclerotic cardio-vascular disease — Duration: 6 mos.

Due to:

Due to:

Other Conditions: Cerebral thrombosis — Duration: 3 days

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Benjamin Miller M.D.

Address 1070 Wilkens Ave Date signed 9/27/44

M. D.

MARION RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21178 V61

G21178 Registered No. 2065

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore + Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore - 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 433 S. Smallwood St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Katherine Kempf

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Adam Kempf

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-15-1871

8. AGE: Years 73 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Eckert
13. Birthplace Germany

MOTHER 14. Maiden Name Louisa Roedgaber
15. Birthplace Germany

16 (a) Informant Mr. Emory J. Kempf
(b) Address 433 S. Smallwood St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10 / 3 / 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director F. B. Hippert & Son
(b) Address 1300 Eutaw Place

19 (a) — (b) Hunter Jon Williams, M.D. Registrar

SEP 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1944 at 12:24 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 9/27 1944 to 9/29 1944 and that I last saw her alive on 9/29 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma from breast	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Curtis Rainey Jr. M. D.
Address St Agnes Hosp Date signed 9/29/44

G21179

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G21179

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1821 N. Mount St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1821 N. Mount St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Gladys Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Col.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 5, 1925

8. AGE: Years	Months	Days	If less than one day
19	1	23	hr. min.

9. Birthplace Baltimore Md. (State, county, and state)

10. Usual Occupation Student

11. Industry or business —

MOTHER / FATHER

12. Name George T. Adams.
13. Birthplace Baltimore Md.
14. Maiden Name Gladys A. Washington
15. Birthplace Baltimore Md.

16 (a) Informant Gladys W. Adams
(b) Address 1821 N. Mount St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Mt Winans

18 (a) Funeral director Mrs Ida Bailey
(b) Address 1421 Jefferson St

19 (a) [illegible] (b) Huntington Williams, M.D.

SEP 30 1944

VS 180

PLEASE WRITE PLAINLY. Use ink. Do not abbreviate. Be sure to answer all questions. Be correct age is especially important. Physicians: please

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28- 1944 at 100 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 20 1944 to Sept 28 1944, and that I last saw her alive on 9-27- 1944

Immediate cause of death: Chronic Valvular Heart Disease — Duration: 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George C. Bliss M. D.
Address 1816 N. Mount St (17) Date signed 9-29

G21180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. 3698

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1207 Winchester St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 1
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1207 Winchester St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Bertie Crane
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Edward Crane
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) April 9 1896

8. AGE: Years	Months	Days	If less than one day
48	5	19	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Own home

FATHER
12. Name Edmond Gatewood
13. Birthplace Virginia

MOTHER
14. Maiden Name Elgin ?
15. Birthplace Virginia

16 (a) Informant Edward Crane
(b) Address 1207 Winchester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Md
18 (a) Funeral director Jes. B. Kelsoff
(b) Address 1303 Pennsylvania Ave
19 SEP 30 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28-1944 at 9:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-1944 to 9-28 1944. and that I last saw her alive on 9-27-1944.

Immediate cause of death Myocarditis

Due to

Due to

Other Conditions Nephritis

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
Long time

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 1029 N. Stricker Date signed 9-30-44

G21181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119-A

Registered No. G21181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1514 Division Street

(c) Hospital or institution: Provident Hospital 15-

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto (If outside city or town limits, write RURAL and give town)

(d) Street No. 160 Gilmor St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Carrera

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/9/44

8. AGE: Years | Months | Days 21 | If less than one day hr. min.

9. Birthplace Balto. Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name Wm Bryan

13. Birthplace Md

MOTHER 14. Maiden Name Pearl Harris

15. Birthplace Md.

16 (a) Informant Pearl Harris

(b) Address 160 Gilmor St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Geo. L. Kelson

(b) Address 1303 Pennsylvania Ave.

19 (a) (Date received by Registrar) SEP 30 1944 (b) Huntington Williams, M.F.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28, 1944, at 3 15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28 1944 to 9/28 1944, and that I last saw h.e alive on 9/28 1944.

Immediate cause of death: Acute Contagious Erysipelas

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy? Negative

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature G. L. Banfield

Address Prov. Hospital Date signed 9/29/44

Von Murchow

G21182 BALTIMORE CITY HEALTH DEPARTMENT G21182

CERTIFICATE OF DEATH 1930

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 111 S. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 111 S. Monroe St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward A. von Minchow Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05-7784

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	white	married

6 (b) Name of husband or wife Agatha nee Joschik

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 25 1880

8. AGE: Years	Months	Days	If less than one day
63	9	4	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Clothing Cutter
11. Industry or business Jacob. Bros.

FATHER 12. Name Frank Von Minchow
13. Birthplace Germany

MOTHER 14. Maiden Name Marie Günther
15. Birthplace Germany

16 (a) Informant Mrs. Agatha Von Minchow
(b) Address 111 S. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10. 2. 44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 2901 Frederick Rd

18 (a) Funeral director Henry H. Wittstadt
(b) Address 4101 E Monument Ave

19 SEP 30 1944 (b) Huntington Williams, M.D. (Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1944 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1940 to Sept 29 1944, and that I last saw h[illegible] alive on Sept 29 1944.

Immediate cause of death Myocardial failure — Duration 3 days

Due to Arteriosclerotic myocarditis — 3

Due to Generalized arteriosclerosis — 3

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J. Scheeler M. D.
Address 5 Y S. Calvert Ave Date signed 9-30-44

G21183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G21183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 761 West Fayette St.
(c) Hospital or institution: 4-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 16days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 761 W. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Steven Leroy Boston 4-09290

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Robert Boston
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Sept 13-44

8. AGE: Years	Months	Days	If less than one day
		16	hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Robert Boston
13. Birthplace

MOTHER
14. Maiden Name Grace Bruce
15. Birthplace South Berwick Main

16 (a) Informant Mary Bruce
(b) Address 761 West Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30-44 (month) (day) (year)
(c) Cemetery or crematory Western Cemetery
Location Baltimore Maryland

18 (a) Funeral director Fredrick A. Cole
(b) Address 1200 West Lombard St

19 SEP 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1944, at 5P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22, 1944 to Sept 29, 1944 and that I last saw h alive on Sept 29 1944

Immediate cause of death Heart Disease. Congulated — Duration

Due to —

Due to —

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Dolan M. D.
Address 876 Walnut St Date signed

C21184 Booker 46 E X

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C21184

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) Just Came

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Rux Fur
(If outside city or town limits, write RURAL and give town)
(d) Street No. None
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Booker

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	C.	Married

6 (b) Name of husband or wife William H. Booker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-2-1890

8. AGE: Years	Months	Days	If less than one day
54	5	25	hr. min.

9. Birthplace Charlotte Virginia
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Deanna Jackson
15. Birthplace Virginia

16 (a) Informant Frankie L. Booker
(b) Address 1610 N. Gilford St.

17 (a) Burial (b) Date thereof Sept 30, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Lena M. Holland
(b) Address 1603 Druid Hill Ave.

19 (a) Date received SEP 30 1944 Registrar Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 27 1944, at 9:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/5 1944, to 9/27 1944, and that I last saw her alive on 9/27 1944.

Immediate cause of death	Duration
Coronary thrombosis	
Post operative complications	
Due to Moderate hypertension	
Cardiovascular disease	
Due to	
Other Conditions Adenocarcinoma, ascending colon c metastases to liver	

(Include pregnancy within 3 months of death)

Date of operation 9/21/44
Major findings of operation: Carcinoma descending colon c metastasis to liver
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Patrick L. Phelan Jr. M. D.
Address Mercy Hospital Date signed 9/27/44

G21185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G21185 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 746 W Fayette
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give county)
(d) Street No. 746 W Fayette (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Sears

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	widow

6 (b) Name of husband or wife Mary Sears
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13 1871

8. AGE: Years	Months	Days	If less than one day
23	2	13	hr. min.

9. Birthplace Suffolk, Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Benjamin Sears
13. Birthplace Suffolk, Va.

MOTHER
14. Maiden Name Rachel Roberson
15. Birthplace Suffolk, Va

16 (a) Informant Reid Sears
(b) Address 849 Lombard St Phila Pa

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 30 1930 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location
(d) Funeral director Mrs Nate R. Wellington
(e) Address 322 N Schroeder St

19 SEP 30 1930 (Date received) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1930 at 8 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 19 1930 to Sept 26 1930 and that I last saw him alive on Sept 26 1930

Immediate cause of death	Duration
Acute Bronchial Catarrh	7 ds
Due to Uremia	2 ds
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 746 W Fayette Date signed Sept 30 1930

G21186

BALTIMORE CITY HEALTH DEPARTMENT 117 B

CERTIFICATE OF DEATH

G21186 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette + Calhoun
(c) Hospital or institution Franklin Square Hosp.
Previously treated by Dr J. Thomas
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 Sollers Point Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Flournoy

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: William

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 9 - 1901

8. AGE: Years: 43 | Months: 5 | Days: 19 | If less than one day: hr. min.

9. Birthplace Keysville - Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business housewife

FATHER 12. Name Alexander Williams

13. Birthplace Va.

MOTHER 14. Maiden Name Betty Rice

15. Birthplace Va

16 (a) Informant Mrs. Alexander Flournoy

(b) Address 119 - Sollers Pt. Rd.

17 (a) Burial (b) Date thereof 10 - 1 - 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

(c) Location Cedar Ln

1944

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N Schroeder St

19 (a) [illegible] (Date rec'd by Registrar) 44 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28- 1944, at 8 00/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1944, to 9-28 1944, and that I last saw h[illegible] alive on 9-28 1944

Immediate cause of death Perforated duodenal ulcer
Due to generalized peritonitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius Block M. D.

Address Franklin Square Hosp. Date signed 9/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age, especially important. Physicians: please write the causes of death clearly and legibly.

ARMOR RESERVED FOR BINDING

G21187

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 194a

G21187 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1618 Abbotston St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Va (b) County
(c) City or town Hilton Village, Newport News
(If outside city or town limits, write RURAL and give town)
(d) Street No. 125 James River Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Miller

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 226-05-1884

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Elizabeth
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1896

8. AGE: Years	Months	Days	If less than one day
48	4	25	hr. min.

9. Birthplace: Richmond, Va.
(Town, county, and state)

10. Usual Occupation: Ass't. Foreman

11. Industry or business: Newport News Ship Bldg. Co.

FATHER
12. Name: Charles E. Miller
13. Birthplace: Pa.

MOTHER
14. Maiden Name: Emma Madison
15. Birthplace: Chesterfield Co., Va.

16 (a) Informant: Mrs. Elizabeth Miller
(b) Address: 125 James River Drive, Hilton Village, Newport News, Va.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 9/30/44 (month) (day) (year)

(c) Cemetery or crematory
Location: Newport News, Va.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 1 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1944, at 2.45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 9/30/44.

G21188

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 117B

G21188 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Robert Greenberg

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Zina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years 54 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county and state)

10. Usual Occupation Mfg. - Button Holes

11. Industry or business

FATHER — 12. Name Not Known
13. Birthplace Russia

MOTHER — 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O'Donnell St

18 (a) Funeral director Jenk & Lewis Inc
(b) Address 1439 E. Baltimore St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 1 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1944, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1944, to Sept 30 1944, and that I last saw him alive on Sept 29 1944.

Immediate cause of death	Duration
Heart failure	
Due to Duodenal ulcer	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/28/44

Major findings of operation: duodenal ulcer perforating into pancreas

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dalton

Address Sinai Hosp Date signed 9/30/44 M. D.

G21189

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54A

G21189

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 20 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2508 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** MANfred Schiff

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, (married), widowed, or divorced.

6 (b) Name of husband or wife Edith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1905

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Germany
(Town, country and state)

10. Usual Occupation Salesman

11. Industry or business

FATHER
12. Name August
13. Birthplace Germany

MOTHER
14. Maiden Name Bertha Fredenstein
15. Birthplace Germany

16 (a) Informant Hospt Records
(b) Address

17 (a) Burial (b) Date thereof 10-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Back + Conkling Sts

18 (a) Funeral director Sol. Levy Inc
(b) Address 1439 E. Baltimore St.

19 (a) 1044 (b) 8
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 19 44 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 19 44 to 9/28 19 44 and that I last saw h[illegible] alive on 9/28 19 44

Immediate cause of death Glioma of Brain

Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/27/44, 9/28/44

Major findings of operation: Cancer of brain

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Stanley

Address Sinai Hospital Date signed 9/30/44

G21190

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 81 A

G21190 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 21 Joseph Hospl.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 3403 Keene Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3403 Keene Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Manuel Theodore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fml	W	

6 (b) Name of husband or wife Jean Theodore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 - 1904

8. AGE: Years	Months	Days	If less than one day
40	9	29	hr. min.

9. Birthplace Donaldsonville La.
(Town, county, and state)
10. Usual Occupation Employee - Dr Cook
11. Industry or business

FATHER
12. Name James Theodore
13. Birthplace Greece

MOTHER
14. Maiden Name Margaret Mantrath
15. Birthplace Greece

16 (a) Informant Jean Theodore
(b) Address 3403 Keene Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-44 (month) (day) (year)
(c) Cemetery or crematory Maryland
Location Balto Co

18 (a) Funeral director Leonard J Hirsch
(b) Address 5305 Harford Ave.

19 (a) Date rec'd by local reg. OCT 1 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30 1944, at 5 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1944 to 9-30 1944, and that I last saw h[illegible] alive on Sept 30 1944

Immediate cause of death Septicemia — Duration

Due to Pyogenic Meningitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Bozeman M. D.
Address St Joseph Hospital Date signed 9-30-44

G21191 Balsan

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119A

G21191 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light Street
(c) Hospital or institution South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Jeffery St (Rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME James L. Balsam D 08546 N

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-44

8. AGE: Years | Months | Days: 3 wks | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Anthony Balsan.
13. Birthplace Italy

MOTHER 14. Maiden Name Varlie Balsan
15. Birthplace Italy

16 (a) Informant Anthony Balsam
(b) Address 917 Jeffery St

17 (a) Burial (Burial, cremation, or removal) Date thereof Oct 1 44 (month) (day) (year)
(c) Cemetery or crematory near Baltimore
Location [illegible]

18 (a) Funeral director Joseph Cannuteri
(b) Address 602 Washington Blvd
(c) [illegible] Washington Williams, Mgr.

OCT 1 1944
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1944 at 8 57 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1944, to 9-29 1944, and that I last saw him alive on 9-29 1944.

Immediate cause of death: acute gastro-enteritis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles A. Wagenhorst M. D.
Address 1213 Light St Date signed 9-30-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73 A

G21192

Registered No. G21192

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Denison St.
(c) Hospital or institution: Crawford Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5721 Highgate Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Crawford Whittington LaMar

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Richard L. LaMar
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1870

8. AGE: Years	Months	Days	If less than one day
74	3		hr. min.

9. Birthplace Pocomoke City Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Whittington
13. Birthplace

MOTHER
14. Maiden Name Portia Richardson
15. Birthplace Md.

16 (a) Informant Richard L. LaMar
(b) Address 5721 Highgate Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-44 (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Pocomoke City. Md.

18 (a) Funeral director G. Howard Strong
(b) Address 3707 W. North Ave (Funeral Home, Williams, Md.)

19 (a) (Date received by Registrar)

OCT 1 1944

VS 180

MEDICAL CERTIFICATION 11.30

20. DATE OF DEATH Sept 29 1944, at P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 11 1944, to Sept 27 1944, and that I last saw her alive on Sept 27 1944.

Immediate cause of death Acute Coronary Failure — Duration
Due to Arteriosclerosis
Due to
Other Conditions Acute Cerebral Hemorrhage
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. L. Homalein M. D.
Address 733 Virginia Ave Date signed 9/30/44

G21193

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93A

G21193

Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4907 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 88 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4907 Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Josephine Hogan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Michael Henry Hogan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feby 17 1856

8. AGE: Years 88 | Months 7 | Days 12 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation At home

11. Industry or business

FATHER
12. Name John Cavanaugh
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Campion
15. Birthplace Ireland

16 (a) Informant Margaret M Hogan
(b) Address 4907 Liberty Heights Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md

18 (a) Funeral director Harry A Annacost
(b) Address 4204 Ridgewood Ave

19 (a) Oct 1 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1944, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Sept 29 1944 and that I last saw h e r alive on Sept 29 1944.

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 4710 Liberty Hts Ave Date signed 9/30/44

Dr. Jack Singer
506 E. North Ave.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21194 ✓ 48b Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 908 East 30th. Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 58years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 908 East 30th. Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena Wagner

3 (b) If veteran, name war	3 (c) Social Security Account No.
----------	----------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George Wagner
6 (c) If alive, give age 54 years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1886

8. AGE: Years	Months	Days	If less than one day
58	7	15	____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

MOTHER / FATHER
12. Name William Rausch
13. Birthplace Germany
14. Maiden Name Catherine Helm
15. Birthplace Germany

16 (a) Informant George Wagner
(b) Address 908 East 30th. Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Maryland

18 (a) Funeral director Ellsworth Armacost
(b) Address 3911 Liberty Heights Ave.
OCT 1 1944 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1944 at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1940 to Sept 29 1944, and that I last saw her alive on Sept 28 1944

Immediate cause of death Carcinomatosis — Duration July 1943

Due to

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack J. Singer M.D.
Address 506 E. North Ave. Date signed 9-29-44

G21195

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94 A

G21195
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto General - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 201 McComas St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George H Stevenson

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 214-03-472

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Kathleen Stevenson
6 (c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.) Oct 21, 1900

8. AGE: Years	Months	Days	If less than one day
43	11	8	hr. min.

9. Birthplace Balto Md
(Town, county, and state)
10. Usual Occupation Statesman Engineer
11. Industry or business Western Md Power House

FATHER
12. Name Benjamin H. Stevenson
13. Birthplace Balto Md

MOTHER
14. Maiden Name Dont know
15. Birthplace Md

16 (a) Informant Kathleen Stevenson
(b) Address 201 McComas St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 3 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Anne Arundel Co
18 (a) Funeral director A. Howard Evans
(b) Address 1400 N. Charles St

OCT 1 1944
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/22 1944, at 6.25 P M

21. I certify that I took charge of the remains described above, held an Inspection-Investigation and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Charles J. Pelbenick M.D.
Medical Examiner.
Date signed 9/22/44

VS 181

G21196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G21196

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4207 Connecticut Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4207 Connecticut Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marguerite Cecilia Sullivan

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: F.
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 27. 1[redacted]
8. AGE: Years 52 | Months 10 | Days 7 | If less than one day: hr. min.
9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Standard Oil Co. N.J.

FATHER
12. Name Michael C. Sullivan
13. Birthplace Ireland.

MOTHER
14. Maiden Name Amelia Wards
15. Birthplace Baltimore Md.

16 (a) Informant Miss Ella Sullivan
(b) Address 4207 Connecticut Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2. 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore Md.
18 (a) Funeral director George A. Farley
(b) Address Fulton Ave & Dolphin St.
19 (Date received by registrar) OCT 2 1944 Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1944 at 8.00 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31 1944 to Sept 29 1944, and that I last saw h[redacted] alive on Sept 29 1944.

	Duration
Immediate cause of death [redacted] Metastatic Sarcoma of Both Lungs.	3 mo.
Due to Sarcoma of Cervix	9 mo.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wilmer K. Gallagher M.D.
Address Catonsville Md. Date signed 9/30/44 M. D.

WILMER K. GALLAGHER

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21197

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5404 Clemmore Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5404 Clemmore Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clermont Rhoades

3 (b) If veteran, name war: World War No 1
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Rhoades
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1892
8. AGE: Years 52 | Months | Days | If less than one day hr. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: Shantsman
11. Industry or business

FATHER
12. Name: Charles L. Rhoades
13. Birthplace: Waynesville Va.

MOTHER
14. Maiden Name: Rebecca Scott
15. Birthplace: Blandsville Va.

16 (a) Informant: Mary Rhoades
(b) Address: 5404 Clemmore Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Dulaney Valley Memory Gardens
Location: Balto, Md.

18 (a) Funeral director: Archibald A. Gaddess
(b) Address: 2101 McCulloh St.

19 (a) Date of registration: Oct 2 1944 Registrar: Washington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944 to Sept 27 1944 and that I last saw him alive on Sept 26 1944

Immediate cause of death: Coronary Thrombosis — Duration: 2 days

Due to: Arteriosclerosis

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: no
(b) Date of occurrence: — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Charles L. Wells
Address: 1776 Park Ave Date signed: Sept 30 44

VS 8

G21198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G21198

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3602 Greenmount Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Helena Arabella Potts

3 (b) If veteran, name war: No
3 (c) Social Security Account No. NONE

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife: Walter G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12 1899

8. AGE: Years 45 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)
10. Usual Occupation Housekeeper
11. Industry or business

FATHER
12. Name Charles M Mohl
13. Birthplace Pa

MOTHER
14. Maiden Name Susanna Miller
15. Birthplace Pa

16 (a) Informant Walter Potts
(b) Address 3602 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/44 (month) (day) (year)
(c) Cemetery or crematory Druhesville
Location Druhesville Md

18 (a) Funeral director Williams Lodge Inc
(b) Address 1217 E Fort Ave

19 OCT 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1 1944, at 4 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1944 to 10/1 1944 and that I last saw h.e.r. alive on 10/1 1944.

Immediate cause of death	Duration
Heart failure	
Due to Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M. D.
Address Md Gen. Hosp. Date signed 10/1/44

G21199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21199 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd St
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Fort George Meade
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Foster Talbott

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	41 [illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 8, 1941

8. AGE: Years	Months	Days	If less than one day
3	2	20	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Foster W. Talbott
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Loretta Dolan
15. Birthplace Pennsylvania

16 (a) Informant Major Foster W. Talbott MC
(b) Address Fort George Meade Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)
(c) Cemetery or crematory Ft Catholic Md
Location Gatemont

18 (a) Funeral director Gilbert Corp Inc
(b) Address 1217 G St NW

19 (a) (Date rec'd) OCT 2 1944 (b) Huntington Williams M.D. Registrar

VS 15a

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 28 1944, at 11:59 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1944 to Sept 28 1944, and that I last saw him alive on Sept 28 1944

Immediate cause of death Cardio respiratory Failure — Duration 2 hrs
Due to Peripheral collapse — 2 hrs
Due to ? —
Other Conditions —
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jack C. Morgan, M.D. M. D.
Address USN Date signed 9-29-44

over

G21200

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E Registered No. G21200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied: the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 Flint St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia May Yoe

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Thomas A. Yoe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1887

8. AGE: Years	Months	Days	If less than one day
57	3	20	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ? Powell
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Mary ?
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. E. Yoe
(b) Address 306 N. Broadway

17 (a) Burial (b) Date thereof 10/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore

18 (a) Funeral director Hilgan Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 2 1944 (b)
(Date rec'd by registrar) Huntington Whitehurst, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1944, at 3:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinomatosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton, M.D.
Medical Examiner.
Date signed Sept. 28 1944

G21201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 309

G21201 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) ~~Street address~~ Sinai Hospital
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 329 S. Smallwood st.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Anna V. Ridgely

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife: George Ridgely
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 17th 1877

8. AGE: Years	Months	Days	If less than one day
67	2	12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At Home

FATHER
12. Name Charles Voss
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Hoff
15. Birthplace Germany

16 (a) Informant Anna Williams
(b) Address 2536 Arunah Ave

17 (a) Burial (b) Date thereof 10/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

OCT 2 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1944, at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1944, to 9-29 1944, and that I last saw her alive on 9-28 1944

Immediate cause of death	Duration
Ventricular fibrillation	
Myocardial Infarction	
Due to Arteriosclerotic Heart Dis.	
Peptic ulcer	
Due to Chronic Interstitial Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: On above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W S Arnett M. D.
Address Sinai Hosp. Date signed 9-29-44

G21202

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G21202 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1911 E. Preston St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1911 E. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Ray

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex: Female — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Hugh T. Ray

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 5th 1876

8. AGE: Years 68 | Months 5 | Days 24 | If less than one day: hr. min.

9. Birthplace: Balto. Md.
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: Joseph E. Norris
13. Birthplace: Balto. Md.

MOTHER — 14. Maiden Name: Elizabeth Bond
15. Birthplace: Balto. Md.

16 (a) Informant: Mildred C. Gerst
(b) Address: 1911 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul St

19 (a) OCT 2 1944 (b) (Date rec'd by registrar) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29th 1944, at 11 42 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1944 to Sept. 29 1944, and that I last saw h[illegible] alive on Sept 29 1944.

Immediate cause of death: Coronary occlusion — Duration: 8 days
Due to: Arteriosclerosis — 5 yrs
Due to:
Other Conditions: Chronic Bronchitis — 5 yrs

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Mark Spiegelwald M. D.
Address: 663 E. Lombard Date signed 9/29/44

VS 190

G21203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 166

G21203 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1318 Riggs ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Milton Betters

3 (b) If veteran, name war —

3 (c) Social Security Account No. 219-18-1167

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Pauline

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 27, 1926

8. AGE: Years 18 | Months 5 | Days 3 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Milton Betters
13. Birthplace Maryland

MOTHER
14. Maiden Name Janette Dungle
15. Birthplace Maryland

16 (a) Informant Milton Betters Daddy
(b) Address 1318 Riggs Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Md

18 (a) Funeral director George E. Edson
(b) Address 1303 Pennsylvania Ave

19 (a) OCT 2 1944 (Date received by registrar) Huntington Md

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29- 1944, at Midnight P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet Wound of Brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9-29-44 at 10 P. M.
(b) Where did injury occur? 1931 Ormes Hill ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Firearm - revolver.

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 9-30-44

G21204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21204 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 614 Reservoir St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Reservoir St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET G. DANIELS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Wm. J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1866

8. AGE: Years	Months	Days	If less than one day
78	7	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Andrew Jamieson
13. Birthplace Ireland

MOTHER
14. Maiden Name M McGee
15. Birthplace Ireland

16 (a) Informant Mrs. Mary G. Ranft
(b) Address 614 Reservoir St. 17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1944 at 10:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1, 1944 to Sept. 28, 1944 and that I last saw her alive on Sept. 28, 1944

Immediate cause of death
Cerebral Thrombosis
Chronic Nephritis
Due to Arterio Sclerosis
Due to
Other Conditions

Duration
10 Yrs
Diagnosed
Years

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. C. Houck Jr
Address 49 W. Mulberry Date signed Sept. 30 1944 M.D.

21205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1671

Registered No. G21205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 Thames St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Boy Markefka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-23-44

8. AGE: Years	Months	Days	If less than one day
		5 6	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Dr. Markefka
13. Birthplace ?

MOTHER
14. Maiden Name Eliz Galleck
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 1/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location: Baltimore

18 (a) Funeral director Fred W Drazgurski
(b) Address 1930 Eastern Ave

OCT 2 1944 (Date received by Registrar) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1944 at 2 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 27 1944 to Sept 29 1944 and that I last saw h[illegible] alive on Sept 29 1944.

Immediate cause of death	Duration
Anuria - anoremia	24 hrs.
Due to possible drug reaction	
possible renal defect	
Due to	
Other Conditions Spontaneous premature labor	
jaundice - cyanosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Clifton D. Garvan Jr. M.D.
Address Johns Hopkins Hosp Date signed 9/30/44

G21206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G21206

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 Thrasher Ct. Baltimore 24 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sandy Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Julia Smith
(c) If alive, give age yrs. 43

7. Birth date of deceased (mo., day, yr.) June 14, 1913

8. AGE: Years	Months	Days	If less than one day
31	3	16	hr. min.

9. Birthplace McCall S.C. (Town, county and state)
10. Usual Occupation Ford Welder
11. Industry or business

FATHER
12. Name Sandy Smith
13. Birthplace S.C.

MOTHER
14. Maiden Name Eva McCray
15. Birthplace S.C.

16 (a) Informant Julia Smith
(b) Address 3023 Thrasher Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/44 (month) (day) (year)
(c) Cemetery or crematory
Location Hamlett, N.C.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brant by me

OCT 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1944 at 7:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1944 to Sept 30 1944 and that I last saw h[illegible] alive on Sept 30 1944.

Immediate cause of death Lobar Pneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. H. Banfield M.D.
Address Provident Hospital Date signed 9/30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21207

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1940 Registered No. G21207

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4251 Sheldon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4251 Sheldon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine E. Fisher

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles T. Fisher

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 2-1879

8. AGE: Years	Months	Days	If less than one day
64	10	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Conrad Vogelsang
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Ott
15. Birthplace Germany

16 (a) Informant Charles E. Fisher
(b) Address 4251 Sheldon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Joppa Ave.

18 (a) Funeral director John A. Miller
(b) Address 2324 Jefferson St.

(a) Filed OCT 2 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28 1944, at 3:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from — 1941 to Sept. 28 1944, and that I last saw h[illegible] alive on Sept. 28 1944.

	Duration
Immediate cause of death Coronary Thrombosis	1 hr.
Due to arteriosclerosis	3 yrs.
Due to	
Other Conditions hypertension.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Dvorak M.D.
Address 101 W. Read St. Date signed 9-30-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21208 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Division St.
(c) Hospital or institution: Provident Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1628 Wind Hill Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Beal Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Margaret

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1878

8. AGE: Years 66 | Months 10 | Days 13 | If less than one day: hr. min.

9. Birthplace Lappahannock, Va (City, county, and state)

10. Usual Occupation Clergyman

11. Industry or business

FATHER
12. Name John Elliott
13. Birthplace Va

MOTHER
14. Maiden Name Kate Beal
15. Birthplace Va

16 (a) Informant Mrs. Margaret Elliott
(b) Address 1628 Windhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto Co. Md.

18 (a) Funeral director Mrs. Geo. H. Stallard
(b) Address 1628 Windhill Ave.

19 (a) OCT 2 1944 (b) Hunter for Williams (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/28 1944 at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/4 1944 to 9/28 1944 and that I last saw h alive on 9/28 1944

Immediate cause of death: Coronary Thrombosis
Due to: Apoplexy
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
If autopsy:

Duration: 6 mos.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature H. Hackney
Address 600 Madeira Date signed 9/2

G21209

AB-89786

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

~~G24009~~

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Division St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Webb

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Widow

6 (b) Name of husband or wife Robert (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4- 1892

8. AGE: Years	Months	Days	If less than one day
52	2	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name George Washington Bowser
13. Birthplace Md.

MOTHER
14. Maiden Name Rosie Johnson
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Asbury Mem. Pk
Location Balto. Co. Md.
18 (a) Funeral director Wm. Chas. H. Holland Inc. Wm. Chas. H. Holland Jr., Mgr.
(b) Address 1631 Druid Hill Ave.
19 (a) OCT 2 (b) 1944 (Date received by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 27 19 44 at 6.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9 1944, to 9-27 1944, and that I last saw h er alive on 9-27 1944.

Immediate cause of death Peritonitis + Cachexia — Duration ?

Due to Primary Carcinoma of ovary I with caranomatosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-16-44
Major findings of operation: Same
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hawk E. Bolton M. D.
Address Balt. City Hosp. Date signed 9/28/44

G21210 | BALTIMORE CITY HEALTH DEPARTMENT | G21210

CERTIFICATE OF DEATH 940

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 E. Fairmount Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 E Fairmount Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward A Slagle

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-10-6165

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lena D Slagle
6 (c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) June 13, 1891
8. AGE: Years 53 | Months 3 | Days 17 | If less than one day: hr. min.
9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Drill pressman
11. Industry or business Black & Decker

FATHER
12. Name Samuel A. Slagle
13. Birthplace Balto Md

MOTHER
14. Maiden Name Annie M. Letton
15. Birthplace Germany

16 (a) Informant Mrs Lena D Slagle
(b) Address 3406 E. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location a. a bo

18 (a) Funeral director A Howard Evans
(b) Address 1400 N Charles St

19 (a) (Signature of registrar) Registered OCT 2 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/14 1943 to 9/30 1944, and that I last saw h 1 alive on 9/16 1944

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles Thom
Address 325 Euclid Ave Date signed 10/1/44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21211

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

930 G21211 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 N. Paca St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 615 N. Paca St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Sue Lawson.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1911

8. AGE: Years	Months	Days	If less than one day
33	5		hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Richard Owens
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant Mrs. Lawson
(b) Address 615 Paca St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-44 (month) (day) (year)
(c) Cemetery or crematory Louis Boston
Location: Va.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date received by registrar) OCT 2 1944 (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29 1944, at 8.30 P.M.

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Hypertensive cardio-vascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh W. B. McNally M.D.
Medical Examiner.
Date signed 9/30/44

G21212

BALTIMORE CITY HEALTH DEPARTMENT ✓ 940 G21212
CERTIFICATE OF DEATH Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lake Dr. near Brookfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 Yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 14 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City ~~or town~~ Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Seville Apts.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME ABBOTT MEYERAN SHEFFLER.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Sadie O. Sheffler.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 24, 1895.

8. AGE: Years	Months	Days	If less than one day
49	8	6	hr. min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)
10. Usual Occupation Salesman:- Books.
11. Industry or business

FATHER
12. Name Samuel Sheffler.
13. Birthplace Hungary.

MOTHER
14. Maiden Name Hannah Kamens.
15. Birthplace Russia.

16 (a) Informant Mrs. Sadie O. Sheffler,
(b) Address Seville Apts.

17 (a) Burial (b) Date thereof 10/3/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director Sonnenmine & Son
(b) Address 1902 Eutaw Place.

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 2 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30th. 1944 at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 1944, to Sept 30 1944, and that I last saw h~~im~~ alive on Sept 30 1944.

Immediate cause of death	Duration
Coronary Thrombosis	½ hour
Due to Coronary Sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Theodore Cooper M. D.
Address 2107 Park Ave. Date signed 10/1/44

Theo. Cooper

G21213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21213
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Ray Semon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1870

8. AGE: Years	Months	Days	If less than one day
73	11	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Herman Seamon
13. Birthplace Holland

MOTHER
14. Maiden Name Hannah
15. Birthplace Germany

16 (a) Informant Mrs. Moses Seamon
(b) Address 433 W. Saratoga St.

17 (a) Burial (b) Date thereof 10/3/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Balto. Hebrew
Location Balto. Md.

18 (a) Funeral director Chas. Sonnheim's Son
(b) Address 1902 Eutaw Place

19 OCT 2 1944 (b)
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1944, at 4 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 14 1944, to Oct. 1 1944, and that I last saw h.e. alive on October 1 1944.

Immediate cause of death	Duration
Carcinoma of L. lung	
Due to	
Due to	
Other Conditions Mitral insufficiency	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: (Yes)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Henry Wagel for M. Goldstein M. D.

Address Levindale Home Date signed Oct. 1/44

G21214 BALTIMORE CITY HEALTH DEPARTMENT G21214

CERTIFICATE OF DEATH

94N Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 N. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Benjamin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widower

6 (b) Name of husband or wife Amelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Riga - LATVIA
(Town, county, and state)

10. Usual Occupation Shipping Clerk

11. Industry or business

FATHER
12. Name Unk
13. Birthplace Riga LATVIA

MOTHER
14. Maiden Name Mollie
15. Birthplace Riga LATVIA

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale
Location Belair Rd & Hamilton Ave

18 (a) Funeral director Clark Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (b)
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1st 1944, at 5 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Slater M.D.
Medical Examiner.
Date signed October 2nd 1944

G21215 ✓ G21215

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700 ✓ Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l Hosp 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2710 Boarman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hyman Snyder

3 (b) If veteran, name war —
(c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Heyman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Sanitary Ship Yard
11. Industry or business

FATHER
12. Name Isaac
13. Birthplace Russia

MOTHER
14. Maiden Name not known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-44 (month) (day) (year)
(c) Cemetery or crematory Greenlawn
Location Phila Rd & Hamilton Ave
18 (a) Funeral director Frank Lewis Inc
(b) Address 1439 E. Baltimore St.
19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151 OCT 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1944, at 3 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage, traumatic
Due to Compound fractures of both lower legs
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 53-00
(a) Date of injury Sept 29 1944 10 A M.
(b) Where did injury occur? Liberty Road, Highway III
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert L. Fraser M.D.
Medical Examiner
Date signed October 2 1944

G21216

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

36

G21216
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Calvert St.
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da.
(e) Length of stay in Baltimore (yrs., mos., or days) 31yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3504 Gibbons Ave
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME George Francis Derr Jr.

3 (b) If veteran, name war: —No—

3 (c) Social Security Account No. 219-05-5277

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Patricia Derr

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1912

8. AGE: Years 31 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Balto, Md. (town, county, and state)

10. Usual Occupation Salesman

11. Industry or business Farm Tractors.

FATHER
12. Name Geo. F. Derr.
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Regina J. Buchman
15. Birthplace Balto, Md

16 (a) Informant Patricia Derr
(b) Address 3504 Gibbons Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 3 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location — Baltimore —

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. WOODEN SUC.) 108 W. NORTH AVENUE

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1944 at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/27 19 44 to 9/30 19 44 and that I last saw h[illegible] alive on 9/30 19 44

Immediate cause of death Card.-Resp. Fail — Duration

Due to Pneumonia. —

Due to Encephalitis. —

Other Conditions (w/a) —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Poliomyelitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Jane Tolan M. D.
Address Mercy Hosp. Date signed 9/30/44

Baby Released by Medical Examiner 9/30/44 T.L.

G21217

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83N

Registered No. G21217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette + John Sts
(c) Hospital or institution: Womens Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hours
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balt.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1105 N. Eutaw Place
(If rural give location)
(e) Citizen of foreign country? S (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Jane Crawford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) (Abt) 7/22/1881

8. AGE: Years	Months	Days	If less than one day
(Abt) 63	2	8	3 hr. 15 min.

9. Birthplace Catonsville Md
(Town, county, and state)

10. Usual Occupation House

11. Industry or business

FATHER
12. Name Fredk. B. Crawford
13. Birthplace Barre, Mass.

MOTHER
14. Maiden Name Eliza Jane Campbell
15. Birthplace Catonsville Md.

16 (a) Informant Mr. Fredk. C. Crawford (Brother)
(b) Address 706 E. Biddle St. City

17 (a) Burial (b) Date thereof 9-21-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto, Md.

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. MOWEN SUC.) 108 W. NORTH AVENUE

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30/44 19 at 3:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/28/44 19 to 9/30/44, and that I last saw her alive on 9/29/44.

Immediate cause of death	Duration
Respiratory failure	
Due to Cerebral hemorrhage	
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Felix Rutledge M.D.
Address Womens Hospital Date signed 9/30/44

Huntington Williams, M.D. Registrar

G21218

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93N

G21218
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry E. Mierzejewski (Majestat)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Dora
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Oct. 9-1893

8. AGE: Years	Months	Days	If less than one day
50	11	20	hr. min.

9. Birthplace Balto.
(Town, county, and state)
10. Usual Occupation Consetionist
11. Industry or business

FATHER
12. Name Stanislaus
13. Birthplace Poland

MOTHER
14. Maiden Name Julia Wyprecht
15. Birthplace

16 (a) Informant Dora Mierzejewski
(b) Address 2002 Eastern ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location German Hill Rd.

18 (a) Funeral director Wm. S. Fralkowski
(b) Address 2007 Eastern ave

19 (a) OCT 2 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1944, at 3 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy / Inspection / or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cardiac Dilatation

Due to Hypertensive Cardiovascular Disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 29 1944

G21219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93d

Registered No. G21219

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1108 S. Streeper St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1108 S. Streeper (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Krolikowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	Married

6 (b) Name of husband or wife Katarzyna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/8/76

8. AGE: Years	Months	Days	If less than one day
68	7	6	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Varnished | Dipper W.
11. Industry or business

FATHER
12. Name Jacob Krolikowski
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Katarzyna
(b) Address 1108 S. Streeper

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year) 10/3/44
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave

18 (a) Funeral director Stephen J. Fratkowski M.D.
(b) Address 1800 S. Kenwood Ave

19 (a) OCT 2 1944 (Must not be later than day registered) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1944 at 730 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3 pm 9-29 1944 to 7 30 pm 9-29 1944 and that I last saw h alive on 9-29 1944.

Immediate cause of death	Duration
(a) Arteriosclerotic	
(b) C.V. Hypertensive Disease	9-29-44
(c) Cerebral Hemorrhage	9-29-44
Due to (d) Myocardial Failure	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury None
23. Signature E A Schmunk M. D.
Address 1428 E 30th Date signed 9-29-44

Robert Lee Graham M.D. C.E. Schmunk M.D.

G21220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 570 W. Univ. Parkway
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. George Thomas Ness

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Mrs Geo. T. Ness

6 (c) If alive, give age 69 [illegible]

7. Birth date of deceased (mo., day, yr.) 12-17- [illegible]

8. AGE: Years 75 [illegible] | Months 9 | Days 16 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Saddlery

11. Industry or business

FATHER
12. Name George W. Ness
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Joanna Thomas
15. Birthplace Baltimore, Md

16 (a) Informant George T. Ness Jr
(b) Address 529 Register Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md

18 (a) Funeral director John Armistead Sons
(b) Address 910 Eutaw Place

OCT 2 1944 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-29 1944 at 9 45 P M

21. I certify death occurred on the date above stated; that I attended deceased from 9-25 1944 to 9-29 1944; and that I last saw him alive on [illegible] 1944

Immediate cause of death: Ruptured Abdominal Aortic Aneurysm — Duration

Due to: Arteriosclerotic Heart disease [illegible]

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: Abdominal Aortic Aneurysm

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. L. Quennell M.D.
Address Union Mem. Hosp. Date signed 9/30/44

W.L. QUENNELL, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21221

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County BALTIMORE
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2409 Fairway, Dundalk (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Snyder

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 216-10-5057

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Tekla

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 28, 1912

8. AGE: Years 32 | Months 8 | Days 3 | If less than one day: hr. min.

9. Birthplace Lansdale, Pennsylvania (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business Bethlehem Steel Companyy

FATHER
12. Name George Snyder
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Florence Pollyetto
(b) Address 418 N. Loudon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 127 St. Paul Street

19 (a) Date received by Registrar OCT 2 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/44 1944, at 9:30 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30/ 1944, to 10/1 1944, and that I last saw h[illegible] alive on 10/1/ 1944

Immediate cause of death Cardio-resp. failure — Duration

Due to Bacterial endocarditis involving aortic valve

Due to Pulmonary edema

Other Conditions Multiple infarcts of spleen, possibly [illegible]
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: Bacterial endocarditis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Atkins, M. D.
Address Sinai Hosp Date signed 10/1/44

J L - 80134 G21222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21222 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.,
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 1643 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Byrd

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1865

8. AGE: Years: 79 | Months: 0 | Days: 0 | If less than one day: hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Byrd
13. Birthplace Md.

MOTHER
14. Maiden Name Lawrena Marshall
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto. Md.

18 (a) Funeral director John C. Miller Inc
(b) Address 2435 E. Oliver St

19 (a) (Date received by registrar) 1944 Huntington Williams Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1944, at 4 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-24 1944, to 10-1 1944, and that I last saw him alive on 10-1 1944.

	Duration
Immediate cause of death: Pulmonary embolus	?
Due to:	
Due to: Bleeding peptic ulcer	2 wks.
Other Conditions: fracture left femur, Thrombophlebitis	2 mos. ?

(Include pregnancy within 3 months of death)

Date of operation 7-26-44

Major findings of operations: Fractured femur.

of autopsy: Pulmonary embolus. Report to ME

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 7-18-44 at 8-2 AM
(c) Where did injury occur? 1643 Milton Ave. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? No
(e) Means of injury: Fell down stairs

23. Signature Hauck & Balton M.D.
Address Balt. City Hosp. Date signed 10/1/44

approved by Howard J. Madeira, M.D.

331852 G21223

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21223 Registered No.

CERTIFICATE OF DEATH 132

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 418 Aisquith St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME James Watkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-30-02

8. AGE: Years 42 | Months 6 | Days — 0 | If less than one day ..... hr. ..... min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Shipper
11. Industry or business

FATHER
12. Name George Watkins
13. Birthplace Va

MOTHER
14. Maiden Name Mary Cook
15. Birthplace Va.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10-4-44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) (b) Huntington Williams M.D.
Filed by registrar OCT 2 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1944, at 10 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19- 1944 to 9-30-1944, and that I last saw deceased alive on 9-30-1944.

Immediate cause of death Respiratory failure — Duration .....
Due to Uremia — .....
Due to Malignant hypertension — .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature William T. Dixon M.D.
Address Johns Hopkins Hospital Date signed 10/1/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

G21224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21224 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1320 Argyle Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Haiston

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4-3-44

8. AGE: Years | Months: 5 | Days: 28 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Bernard Hairston
13. Birthplace N. C.

MOTHER
14. Maiden Name Sophia Hairston
15. Birthplace N. C.

16 (a) Informant Ulurich Perkins
(b) Address 1320 argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave

19 (a) OCT 2 1944 (Date rec'd by Registrar)
Huntington Williams, Md. Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1944 to Oct 2 1944 and that I last saw h.e alive on Oct 2 1944.

Immediate cause of death	Duration
(a) Contusion of Bronchopneumonia (Terminal)	
Due to	
Due to	
Other Conditions Whooping Cough.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Provident Hospital Date signed 10/2/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G21225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

112

G21225

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) ~~Baltimore~~ City, Maryland
(b) Street address
(c) ~~Hospital or~~ institution: Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 813 W. Mulberry St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Merriman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 9, 1943

8. AGE: Years 1 | Months 6 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Merriman
13. Birthplace Baltimore, Md

MOTHER 14. Maiden Name Lucille Ashby
15. Birthplace Crisfield, Md

16 (a) Informant Lucille Merriman
(b) Address 813 W Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 2221 Schroeder St

19 (a) (Date received by Registrar) (b) Thurlington Williams, M.D. (Registrar)

OCT 2 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1944, at 3 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1944, to Sept 30 1944, and that I last saw h[illegible] alive on Sept 30 1944.

Immediate cause of death: Status Asthmaticus — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
Means of injury

23. Signature G J Bamford M.D.
Address Provident Hospital Date signed 9/30/44

G21226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 64c

G21226 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 8
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3010 Parkside Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mark R. Scholl

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Catherine E. Scholl
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1875

8. AGE: Years	Months	Days	If less than one day
69	1 0	1 27	hr. min.

9. Birthplace Walkersville, Fred'k County Md. (Town, county, and state)
10. Usual Occupation Retired Lieut. Police Dept.
11. Industry or business

FATHER
12. Name Randolph Scholl
13. Birthplace Md.

MOTHER
14. Maiden Name Louise Woods
15. Birthplace Md.

16 (a) Informant Mrs. Catherine E. Scholl
(b) Address 3010 Parkside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director F.B. Wippert & Son
(b) Address 4300 Eutaw Place

19 (a) OCT 2 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1944, at 11:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Bullet wound of Head

Due to

Other Conditions Mental Dependency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 1, 1944 M.
(b) Where did injury occur? 116 N. Chester St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Shot self.

23. Signature Robert Lee Graham, M.D. Medical Examiner.
Date signed Oct. 2, 1944

M. D. B. 1264-6

✓ 93d G21227

G21227 **HEALTH DEPARTMENT—CITY OF BALTIMORE**

CERTIFICATE OF DEATH

1. PLACE OF DEATH

Registered No.....

CITY OF BALTIMORE: (No. 112 N. Patterson Pk. Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Walenty Stefankiewicz

(a) Residence: No. 112 N. Patterson Pk. Ave. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Antonina Stefankiewicz

6. DATE OF BIRTH (month, day, year) 1864

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT James Stefankiewicz, Son
(Address) 112 N. Patterson Pk. Ave.

18. BURIAL, CREMATION, OR REMOVAL
Place St. Stanislaus Cem. Oct. 3 19 44

19. UNDERTAKER John M. Weber
(Address) 401 S. Chester St.

20. FILED Huntington Williams M.D.
Registrar.
OCT 2 1944

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Sept 30 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1944 to Sept 30, 1944

I last saw h.im alive on Sept. 25, 1944 Death is said to have occurred on the date stated above, at 4 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Hypertensive Arterio-Vascular Disease,	
Myocardial Insufficiency	

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Antoni Stefankiewicz M. D.

(Address) 1129 East St.

—THIS IS PERMANENT RECORD. BE UNFAILING INK—THE information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G21228 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3724 Old Frederick Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3724 Old Frederick Road (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ann Nicholson

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Richard J. Nicholson
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) March 31, 1870
8. AGE: Years 74 Months 7 Days 29 If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Miller
13. Birthplace Germany

MOTHER
14. Maiden Name ? Habaroon
15. Birthplace Germany

16 (a) Informant: Elizabeth W. Dorsch
(b) Address 1622 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-3-1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George W. Schwab
(b) Address 2101 Frederick Avenue

19 (a) OCT 3 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 23 1944 to Sept 30 1944, and that I last saw h[illegible] alive on Sept 30 1944.

Immediate cause of death: Uremia — Duration: 3 Months
Due to: Senile Vascular Renal Disease & Hypertension — 4yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place; in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Elliot W. Johnson M. D.
Address 3432 Wisteria Ave Date signed

VS 150

MARON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G21229 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 719 S. Charles
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 719 S. Charles (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sallie Peterson

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1918

8. AGE: Years 26 | Months | Days | If less than one day hr. min.

9. Birthplace Maysville. S.C (town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Samuel Hollimon
13. Birthplace S. C.

MOTHER
14. Maiden Name Mary Hats
15. Birthplace S.C.

16 (a) Informant Geo. Peterson
(b) Address 719 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4-44 (month) (day) (year)
(c) Cemetery or crematory Sumter. S.C
Location

18 (a) Funeral director James adams
(b) Address 142 W. Hill

19 (a) (b) Registrar
OCT 3 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1944, at 1.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/10 1944 to 9/29 1944, and that I last saw h alive on 9/29 1944.

Immediate cause of death acute Glomerulo nephritis — | Duration 4 mo
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 6/29/44
Major findings of operation: Diagnosis plus
of autopsy: H Hopkins

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Frankel M. D.
Address 1222 W Lee Date signed 10/1/44

G21230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G21230

Registered No. 9212

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3315 Dupont Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ****
(c) City or town Baltomore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3315 Dupont Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George F.Pullman

3 (b) If veteran, name war ----
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: Wht.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Carolyn D.Pullman
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Nov.29,1878

8. AGE: Years 65 | Months 10 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Florist

FATHER
12. Name John Pullman
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Hammerbacker
15. Birthplace Germany

16 (a) Informant Mrs.Carolyn D.Pullman
(b) Address 3315 Dupont Ave.

17 (a) Burial (b) Date thereof Oct.4,1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Robert S.Little
(b) Address 2700 Edmondson Ave.

19 (a) ... (b) ...
(Filed rec'd by registrar) Registrar

OCT 5 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1944 19..., at 10.40 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from JUNE 8 1944, to OCT 1 1944 and that I last saw h/m alive on OCT 1 19 44

Immediate cause of death: Mitral insufficiency — Duration: 4 mo

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Hugh S. Hubert M. D.
Address 680 Park Heights Ave. Date signed 10/2/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21231 — BALTIMORE CITY HEALTH DEPARTMENT — G21231

CERTIFICATE OF DEATH 93D

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dukeland St.
(c) Hospital or institution West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2419 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary L Fox

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-09-2650

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Harry C Fox
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22nd 1883

8. AGE: Years	Months	Days	If less than one day
60 61	11	19	hr. min.

9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Sales Lady
11. Industry or business Lace Buyer

FATHER
12. Name Henry Stinchfield
13. Birthplace Bath Me

MOTHER
14. Maiden Name Margret Leonard
15. Birthplace Baltimore Md

16 (a) Informant Hattie Stinchfield Sewitz
(b) Address 2419 Edmondson Ave Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4th 44 (month) (day) (year)
(c) Cemetery or crematory Westview Balto
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 (a) (Filed by registrar) (b) Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1944 at 11:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944, to 10/2 1944, and that I last saw her alive on 10/2 1944.

Immediate cause of death Complete Heart Block — Duration

Due to Adams-Stokes Attack

Due to Bundle-Branch block.

Other Conditions Acute C V D
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. H. Taylor M.D.
Address Westover Va Date signed 10/2/44

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21232 CERTIFICATE OF DEATH 130 G21232

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 1345 Hull St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Phillis Ann Madden

If U. S. Veteran specify WAR

(a) Residence: No. 1345 Hull St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Mar. 21st 1940

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
4	5-6	11	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. None

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Kentucky

FATHER

13. NAME Charles E. Madden

14. BIRTHPLACE (city or town) (State or country) Kentucky

MOTHER

15. MAIDEN NAME Annie Smith

16. BIRTHPLACE (city or town) (State or country) Kentucky

17. INFORMANT Charles E. Madden
(Address) 1345 Hull St.

18. BURIAL, CREMATION, OR REMOVAL
Place Ashland, Kentucky Date 10/3 19 44

19. UNDERTAKER Charles F. Dill.
(Address) 1501 E Fort Ave

20. FILED OCT 3 1944 Registrar

Huntington for Millard

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct. 2, 19 44

22. I HEREBY CERTIFY, That I attended deceased from Sept. 1, 19 44 to Oct. 2, 19 44

I last saw her alive on 9-30, 19 44 Death is said to have occurred on the date stated above, at 5 A.m.

The principal cause of death and related causes of importance were as follows:

	Duration
Miliary Tuberculosis	3 wks
	6 wks.
Whooping Cough	6 wks.

Other contributory causes of importance

Was an operation performed? No Date of

For what disease or injury?

Name of operation Tuberculin test and

What test confirmed diagnosis? [illegible] Was there an autopsy? No

22. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A. L. Lollar M. D.

(Address) 707 E. Fort Ave

WRITE PLAINLY, IN PEN AND INK. ENTRIES MUST BE MADE IN PERMANENT RECORD. Every item information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G21233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45F

G21233 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 547 Fayette Ave.
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 547 W Fayette Ave
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew J. Rosch

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1905

8. AGE: Years	Months	Days	If less than one day
39	1	23	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name R H Rosch
13. Birthplace S C

MOTHER 14. Maiden Name Reynolds
15. Birthplace S C

16 (a) Informant Katie Murray
(b) Address 5-49 Lapsley

17 (a) Removal (b) Date thereof 10/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Camden S C
Location

18 (a) Funeral director A Dolphus Halsted
(b) Address 918 Druid Hill Ave

19 (a) DCT 3 1944 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 19 44, at 1230 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 19 44, to Oct 2 19 44, and that I last saw h. alive on Oct 1 19 44.

Immediate cause of death Carcinoma of Throat — Duration 4 months

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation July 14 Johns Hopkins Hospital
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E William Fay M. D.
Address 1928 Pa. Ave. Date signed 10/3/44

G21234

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13

G21234 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6642 Holabird Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 24 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6642 Holabird Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME VIRGINIA M. DAVIS

3 (b) If veteran, name war ——
3 (c) Social Security Account No. ——

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frank P. Davis
6 (c) If alive, give age 58 years
7. Birth date of deceased (mo., day, yr.) Feb. 13, 1893
8. AGE: Years 51 | Months 6 | Days 18 | If less than one day ... hr. ... min.
9. Birthplace Buffalo, N.Y.
(Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Gus. Mosses
13. Birthplace New York

MOTHER
14. Maiden Name Ada Sheppard
15. Birthplace Virginia

16 (a) Informant Frank P. Davis
(b) Address 6642 Holabird Ave.--24

17 (a) Entombment (b) Date thereof 10/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 (a) ... (b) ...
(Date rec'd by registrar) Registrar

OCT 3 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct., 1, 1944, 3:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1943, to Oct 1 1944, and that I last saw h[illegible] alive on Sept 28 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration 18 years

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David H. Andrew M. D.
Address 2 Kinsley Rd Roland Md. Date signed

G21235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

Registered No. G21235

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1413 W. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1413 W. Lafayette Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Driver

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Wm. E. Driver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5, 1863

8. AGE: Years	Months	Days	If less than one day
80	11	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name George Gibson
13. Birthplace Md.

MOTHER
14. Maiden Name Mary E. Jones
15. Birthplace Md.

16 (a) Informant Mrs. Lula Morris
(b) Address 1413 W. Lafayette Ave.

17 (a) Burial (b) Date thereof 10-3-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) OCT 2 1944 (Signature) Registrar for Millicent Mc...
(Date received by registrar) (Registrar)

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-29-1944 to 9-30 1944, and that I last saw h[illegible] alive on 9-29-1944

Immediate cause of death: Chronic Valvular disease of heart — Duration: three yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Ed. L. Camper M. D.
Address 639 N. Carey St Date signed 10-2-44

G21236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G21236

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DO NOT WRITE IN SPACES RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 W Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 W Baltimore St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine Kremer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 9 1866

8. AGE: Years 78 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Kremer
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Long
15. Birthplace Germany

16 (a) Informant's name Emma Kremer
(b) Address 1826 W Baltimore St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore Md

18 (a) Funeral director Geo A Farley
(b) Address Fulton & Fayette

19 (a) (b) (Date rec'd by registrar) Huntington Williams M.D.

YS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1944, at 8.10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to October 1 1944, and that I last saw her alive on October 1 1944.

Immediate cause of death	Duration
Myocardial failure	
Due to Generalized Lymphosarcoma arteriosclerosis C.V. disease	1 yrs
Due to Diabetes mellitus	
Other Conditions Diabetic gangrene Right foot	9 Months

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John F. Coolahan

Address 24 N. Fulton Ave Date signed 10/2/44 M. D.

G21237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ G21237

46 E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 10. Hyso Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ernestine Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Married

6 (b) Name of husband or wife. Albert.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-18-02

8. AGE: Years	Months	Days	If less than one day
41	9	14	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Ernest Milligan
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret McCarthy
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 5 44 (month) (day) (year)
(c) Cemetery or crematory Hill Crest
Location Federalsburg Md.

18 (a) Funeral director J. Frantom Son.
(b) Address Federalsburg Md.

19 (a) OCT 7 (b) Date filed by registrar Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1944 at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2, 29 1944 to Oct 2 12 30 1944, and that I last saw HER alive on OCT 2 1944.

Immediate cause of death Acute Intestinal obstruction — Duration 24 hrs

Due to Cancer of the Colon — 24yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith M. D.

Address Date signed

621238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. 621238

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution West Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d.
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1002 N. Dukeland St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGIA E. FINK

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Harry L.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1882 April 29

8. AGE: Years: 62 | Months: 5 | Days: 2 | If less than one day: hr. min.

9. Birthplace: Md West Falls, (Town, county, and state)

10. Usual Occupation: --

11. Industry or business

FATHER
12. Name: Henry M. Clary
13. Birthplace: Md.

MOTHER
14. Maiden Name: Annie R. Hood
15. Birthplace: Md.

16 (a) Informant: Mr. Wallace H. Sellman
(b) Address: 428 N. Pulaski St. 23

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/4/44 (month) (day) (year)
(c) Cemetery or crematory: Prospect Cem.
Location: Mt. Airy, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 3 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 1 1944, at 3:10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Oct 1 1944, and that I last saw h[illegible] alive on Oct 1. 1944.

Immediate cause of death	Duration
arteriosclerotic heart disease	
Due to	
Due to general arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address: West Baltimore General Hosp. Date signed: 10-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

G21239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47c

Registered G21939

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Linden Ave.
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) ***13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Linden Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Friedman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Henry Friedman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 7th. 1893

8. AGE: Years	Months	Days	If less than one day
50	9	24	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Joseph Hoppa
13. Birthplace Poland

MOTHER
14. Maiden Name Josephine Jakubowski
15. Birthplace Poland

16 (a) Informant Misses Friedman
(b) Address 2001 Linden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4th. 44 (month) (day) (year)
(c) Cemetery or crematory Lady of Field
Location Church, Millersville, Md

18 (a) Funeral director Chas. F. Evans & Son
(b) Address 118 W. Mt. Royal Ave.

19 (a) (Date received by registrar) OCT 3 1944 Huntington Hill

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1944 at 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Oct 1 1944 and that I last saw h alive on Sept 30 1944

Immediate cause of death Bronchus Cyst Carcinoma — Duration 1/2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sol Smith

Address 1232 E. North Ave. Date signed 10/2/44

Balto 2, Md.

G21240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21240 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Woodyear St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Valentine

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/5/1895

8. AGE: Years 49 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Wm Valentine
13. Birthplace Md

MOTHER
14. Maiden Name Lucinda Lindsey
15. Birthplace Md

16 (a) Informant Ophelia Johnson
(b) Address 1715 Woodyear St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus
Location Md.

18 (a) Funeral director Rev. G. Kelsey
(b) Address 1363 Presstman St.

19 (a) (Date received by registrar) (b)

OCT 3 1944

VS 15V

Funeral for William Md Provident Hospital

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1944, at 6:25 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 1 1944 and that I last saw h[illegible] alive on Oct. 1 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions Essential Hypertension
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Jos Bampus M. D.
Provident Hospital Date signed 10/2/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G21241

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

50

G21241 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3201 Monadonnock
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3201 Monadonnock (If rural give location)
(e) Citizen of foreign country? ~~Natural~~ (Yes or No)
If yes, name country

3 (a) FULL NAME Stella Larcos

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) ~~Single~~, married, ~~widowed~~, or ~~divorced~~.

6 (b) Name of husband or wife George Larcos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/15/1889

8. AGE: Years	Months	Days	If less than one day
55	11	16	hr. min.

9. Birthplace Greece (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Kondoale
13. Birthplace Greece

MOTHER
14. Maiden Name Stella Ponderos
15. Birthplace Greece

16 (a) Informant Husband
(b) Address 3201 Monadonnock

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Greek Orthodox Evangelistes
Location Baltimore, Md.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 (a) Oct 2 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 5

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1944 at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from April 1 1944 to Oct 1 1944 and that I last saw h[illegible] alive on Sept 30 1944

Immediate cause of death Cancer - Stomach — Duration 1 yr.
Due to
Due to
Other Conditions Broncho-pulmonary
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature George Govatos
Address 101 N. Read St Date signed 10/5/44

G21242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

G21242 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 9
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 510
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3914 Bateman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Late John H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1889

8. AGE: Years	Months	Days	If less than one day
58	2	21	hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Levy Adler
13. Birthplace Russia

MOTHER
14. Maiden Name Rachel Hordes
15. Birthplace Russia

16 (a) Informant Chester Miller
(b) Address 3914 Bateman Ave

17 (a) Burial (b) Date thereof October 4, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 OCT 3 1944 Date rec'd by registrar Thurlington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1944, at 9:46 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1944, to 10-1 1944, and that I last saw her alive on 10-1 1944

Immediate cause of death Cardio resp. failure — Duration

Due to Pulmonary edema,

Due to metastases of Ca of Ut. breast

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Ashman M. D.
Address Sinai Hosp Date signed 10/4/44

G21243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G21243

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1313 Bayard St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1313 Bayard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Edward Jenkins

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mary E.
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 10/7/1873

8. AGE: Years 69 | Months 11 | Days 23 | If less than one day: 2 hr. min.

9. Birthplace Powhatton Co. Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Wm. T. Jenkins
13. Birthplace Va.

MOTHER
14. Maiden Name Martha Funn
15. Birthplace Va.

16 (a) Informant Mary E. Jenkins (Wife)
(b) Address 1313 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/1944 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem'l Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) (Signature of registrar) (b) Huntington Williams, M.D.

OCT 3 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/29/44 19 8:25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Sept 29 1944 and that I last saw him alive on Sept 29 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration:
Due to: Hypertension Cerebral Vascular Renal
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Williams M. D.
Address 825 N. Fremont Ave Date signed 10/3/44

G21244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G21244

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 200 7 East St
(c) Hospital or institution:
10
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1409 Madison ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Dorsey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1897

8. AGE: Years	Months	Days	If less than one day
47	3	19	hr. min.

9. Birthplace Ft. Marys Co., Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Samuel Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Coleman
15. Birthplace Md.

16 (a) Informant Annie Watts
(b) Address 1409 E. Madison St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1600 Brantley ave

19 OCT 3 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Tuberculosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed October 2nd 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1084

G21245 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 25 N. Central Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 25 N. Central Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Webb

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/23/44

8. AGE: Years | Months: 5 | Days: 4 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Alonzo Webb
13. Birthplace North Carolina

MOTHER
14. Maiden Name Elarine Wesnne
15. Birthplace North Carolina

16 (a) Informant Elarine Webb
(b) Address 25 N Central Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brentley ave.

19 (a) OCT 3 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1944, at 7:25 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Acute Interstitial pneumonia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham, M.D. Medical Examiner.
Date signed Oct. 2, 1944

G21246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G21246
Registered No.

JO #16114

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13-8 - 24
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore City Hosp. Infirmary
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter Simpson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1870

8. AGE: Years 74 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace St. Louis, Missouri
(Town, county, and state)

10. Usual Occupation Night-watchman

11. Industry or business Unemployed

FATHER
12. Name Peter Simpson
13. Birthplace St. Louis, Missouri

MOTHER
14. Maiden Name Fannie Martin
15. Birthplace St. Louis, Missouri

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Liberty Ave

19 OCT 3 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 28, 1944, at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-44 19 to 9-28-44 19, and that I last saw him alive on 9-28-44 19

Immediate cause of death Hypertensive cardiovascular disease; acute and chronic pyelonephritis

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of autopsy: Biopsy correspond to above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Calvery Jr. M. D.
Address City Hosp. Date signed 10-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

File G21247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G21247 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 years
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Aged Home
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Rebecca Blumberg

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. W.

6 (b) Name of husband or wife Hymen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1855

8. AGE: Years	Months	Days	If less than one day
89			hr. min.

9. Birthplace Lithuania (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Yehuda Leib
13. Birthplace Lith

MOTHER
14. Maiden Name Feiga
15. Birthplace Lith

16 (a) Informant Aged Home
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-44 (month) (day) (year)
(c) Cemetery or crematory Herring Run
Location Phil Rd & Bowley Lane

18 (a) Funeral director Jacob Levin Inc
(b) Address 1432 E. Balto St

OCT 3 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1944, at 2 15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944 to October 2 1944, and that I last saw h er alive on October 2 1944.

Immediate cause of death: Hypostatic pneumonia — Duration
Due to: Chronic myocarditis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel for H. Goldstein M. D.
Address Levindale Home Date signed Oct. 2, 44

G21248

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

G21248 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Raynor Ave
(c) Hospital or institution: West Balto General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-7-5
(e) Length of stay in Baltimore (yrs., mos., or days) 2-24 and 9-1 to 10-2-44 30442

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 W. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Pasta

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Hyman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1891 (or 95?)

8. AGE: Years 49 | Months 4 | Days 18 | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name Morris Siegel

13. Birthplace

MOTHER 14. Maiden Name Etta Felle

15. Birthplace Russia

16 (a) Informant Miss Pasta

(b) Address 2122 W North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-44 (month) (day) (year)

(c) Cemetery or crematory Pikesville

Location

18 (a) Funeral director Jack Lewis Ind

(b) Address 1739 E. Balto St

19 (b) Date received by local registrar OCT 3 1944 Huntington Williamson, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2 19 44 at 6 1 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-44 to 10-2-44, and that I last saw h[illegible] alive on 10-1 1944

Immediate cause of death Anamitosis — Duration 2-3 mo

Due to Multiple peritoneal metastases — 2

Due to Carcinoma, serous cystadeno — 2

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 2-5-44

Major findings of operation: Ca ovary & metastases

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Bardeen M. D.

Address West Baltimore General Hosp Date signed 10-2-44

G21249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. G21249

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~ or days) 6 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6406 Clearspring Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss ANNIE VANDEVENTER

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: ~~Single~~ Widowed
6 (b) Name of husband or wife: Morgan Van Deventer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 15th 1866

8. AGE: Years 78 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Loudoun Va.
(Town, county, and state)

10. Usual Occupation None
11. Industry or business —

FATHER
12. Name MORTIMER WALTMAN
13. Birthplace Va

MOTHER
14. Maiden Name ELLEN FAIRFAX
15. Birthplace Va

16 (a) Informant Patient
(b) Address

17 (a) Burial (b) Date thereof 10/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

OCT 3 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 2 - 1944, at 10:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1944, to 10-2-1944, and that I last saw h[illegible] alive on 10-2-1944.

Immediate cause of death	Duration
Coronary Thrombosis	7 days.
Congestive Failure	
Pulmonary Embolism ?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. V. Palmer M.D.
M. D.
Address University Hospital Date signed 10-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21250

Liebus

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G21250 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 706 W Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Liebus

3 (b) If veteran, name war ✓

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1897

8. AGE: Years	Months	Days	If less than one day
47			hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Frank Liebus
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Jennie Buda
(b) Address 537 Washington Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd

18 (a) Funeral director Joseph Kaminski Jr
(b) Address 537 Washington Blvd

19 (a) OCT 3 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1944, at 2:35 P

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept. 30 1944 at 10 P.M. 4/2 20
(b) Where did injury occur? In front of 706 W Fayette St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Fall down steps

23. Signature Robert C. Gutman M.D. Medical Examiner.
Date signed Oct. 2, 1944

G21251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 477

G21251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 S Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 334 S Bruce St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Balazs

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 718-03-4470

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ethel Balazs
6 (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.) Dec 24 1878

8. AGE: Years 65 | Months 66 | Days 9 | If less than one day: hr. 7 min.

9. Birthplace: Yugoslovia (Town, county, and state)
10. Usual Occupation
11. Industry or business: Tailor

FATHER
12. Name: Paul Balazs
13. Birthplace: Yugoslavia

MOTHER
14. Maiden Name: Erzsebet Asziy
15. Birthplace: Yugoslovia

16 (a) Informant: Ethel Balazs
(b) Address: 334 S Bruce St

17 (a) Burial, cremation, or removal: Burial (b) Date thereof: Oct 4 1944 (month) (day) (year)
(c) Cemetery or crematory
Location: Woodlawn Cem

18 (a) Funeral director: Rott & B.M. Walters
(b) Address: Rott & Stricker Sts

19 OCT 3 1944 (Date rec'd by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 1st 1944, at 4a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 28 1944 to Oct 1 1944, and that I last saw him alive on Sept 30 1944.

Immediate cause of death (Efect) Cerebral Hemorrhage
Due to
Due to
Other Conditions Pulmonary Oedema
Metastasis to Lungs
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Nicholas A. Nichols M. D.
Address 215 W Lafayette Ave Date signed Oct 2/44

G21252
330709

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH ✓ 106 B

Registered No. G21252

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) "

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Bell (If outside city or town limits, write RURAL and give town)
(d) Street No. Route 1 - Box 52 (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William M. Hall
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓
4. Sex: male
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Lona Hall
6 (c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) 7-21-97
8. AGE: Years 47 Months 2 Days 12 If less than one day ..... hr. ..... min.
9. Birthplace Fla. (Town, county, and state)
10. Usual Occupation farmer
11. Industry or business

FATHER
12. Name Alfred Hall
13. Birthplace Fla

MOTHER
14. Maiden Name Mary Woodward
15. Birthplace Fla

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5/44 (month) (day) (year)
(c) Cemetery or crematory Mayfair Church
Location Gibsonton Co, Fla.
18 (a) Funeral director Dolan Critchell & Howe
(b) Address 1900 Eutaw Place

OCT 3 1944 (date rec'd by registrar) Hunter for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1944 at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Oct 3 1944, and that I last saw him alive on Oct 3 1944.

Immediate cause of death Atelectasis + emphysema — Duration

Due to Pt taken to laboratory

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Bronchiectasis lung

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Longmire Jr.
Address Johns Hopkins Hosp Signed 10/5/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G21253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21253

Registered No. _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address _____
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County _____
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 E. 22nd St
(If rural give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3 (a) FULL NAME Miss Elizabeth Dwyer

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife _____

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 1870

8. AGE: Years 74 | Months _____ | Days _____ | If less than one day: _____ hr. _____ min.

9. Birthplace Chesterfield Md (Town, county, and state)

10. Usual Occupation Dress Maker

11. Industry or business _____

FATHER
12. Name John W Dwyer
13. Birthplace Chesterfield Md

MOTHER
14. Maiden Name Mrs Rose Hyder
15. Birthplace Chesterfield Md

16 (a) Informant Miss Dwyer
(b) Address 509 E. 22nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location _____

18 (a) Funeral director Mary M Wheatley
(b) Address 501 E. 22nd St

19 (a) _____ (b) _____
(Date received by registrar) (Registrar)
OCT 3 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Oct 1 1944, at 9 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-14 1944 to Oct 1 1944 and that I last saw her alive on Sept 30 1944.

	Duration
Immediate cause of death Uremia	
Due to Arteriosclerotic C-V disease & Congestive heart failure	
Due to _____	
Other Conditions _____	

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature Thomas J Brennan M.D.
Address St Joseph Hospital Date signed 10-1-44

G21254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓46E

Registered No. G21254

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE NO ENTRIES IN SPACES RESERVED FOR BOARD

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1003 Dukeland ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Bucs.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1003 Dukeland ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara E. Timanus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/25/1880

8. AGE: Years 64 | Months 8 | Days 7 | If less than one day hr. min.

9. Birthplace Bucs.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm. M. Timanus
13. Birthplace Bucs.

MOTHER
14. Maiden Name Clara Martin
15. Birthplace Bucs.

16 (a) Informant Family
(b) Address 1003 Dukeland St.

17 (a) B. (Burial, cremation, or removal) (b) Date thereof 10-3-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood.
Location Taylor Ave.

18 (a) Funeral director Daniel L. McCarthy
(b) Address 1206 E. Fayette.

(Date rec'd by Registrar) OCT 3 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1944, at 6:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-22 1940 to 10-2 1944, and that I last saw h[illegible] alive on 10-2 1944

Immediate cause of death Carcinoma of Colon — Duration 1½ yrs

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jean Adelman M. D.
Address 1201 Eyster Ave Date signed 10-2-44

G21255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 4813 G21255

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARK "RESERVED FOR BINDING"

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2022 Penrose Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2022 Penrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leona C. Chapman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James M. Chapman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 2, 1897.

8. AGE: Years	Months	Days	If less than one day
46	10	-	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation H.W.
11. Industry or business

FATHER
12. Name Thomas K. Hutchinson
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth D. Westland
15. Birthplace Md.

16 (a) Informant Mr. James M. Chapman
(b) Address 2022 Penrose Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5/44. (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn, Md.

18 (a) Funeral director Harry H. Nuitzke
(b) Address 4107 Edmondson Ave.

19 (a) (Date rec'd by registrar) (b) Huntington-Wilkins, M.D.

OCT 3 1944

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2/44. 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Oct 2 1944, and that I last saw her alive on Sept 28 1944

Immediate cause of death Carcinoma uterus
Due to fundus

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Encircled Carcinoma fore corpus uteri

of autopsy:

Duration: 16 mo

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Collins M. D.
Address 332 Frederick Ave Date signed 10-3-44

C21256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

C21256
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 193 Gittings Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 12 (If outside city or town limits, write RURAL and give town)
(d) Street No. 193 Gittings Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis Bowden Ports

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of ~~husband or~~ wife Sarah Elizabeth Keyes
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1866

8. AGE: Years	Months	Days	If less than one day
78	- 1	17	— hr. — min.

9. Birthplace Waynesboro, Pa. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Garage Owner

FATHER
12. Name George W. Ports
13. Birthplace Pa.

MOTHER
14. Maiden Name Elizabeth Algire
15. Birthplace Md.

16 (a) Informant F. Willard Ports
(b) Address 193 Gittings Ave., Balto. 12, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Md.

18 (a) Funeral director John Burns Long
(b) Address Towson, Maryland

19 (Date received by registrar) OCT 3 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1944, at 4:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944, to Oct 1 1944, and that I last saw him alive on Oct 1 1944.

Immediate cause of death	Duration
Coronary Sclerosis	6 mos
Due to Arteriosclerosis	14 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Long M. D.
Address 6?? N. Howard Date signed 10/3/44

G21257

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21257
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner ave
(c) Hospital or institution: West Baltim. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Fairmount (If outside city or town limits, write RURAL and give town)
(d) Street No. 725 Renard St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY L. REILLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex fem. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 30 1889

8. AGE: Years 53 55 | Months 10 | Days - | If less than one day hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Amer. Bk. Stationery

FATHER
12. Name Cornelius Reilly
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Gilboy
15. Birthplace Ire.

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director E. J. Fanning & Son
(b) Address OCT 3 1944 E. Lafayette Ave.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30 1944 at 8 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29. 1944. to Sept. 30 1944. and that I last saw h. alive on Sept 30 1944.

Immediate cause of death Cerebral hemorrhage — Duration

Due to (not traumatic)

Due to Hypertensive heart disease

Other conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Walter E. Fanning M. D.
Address West Baltimore General Hospital Date signed 9-30-44

G21258 G21258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

STATE OF MARYLAND—RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3012 Reisterstown Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3012 Reisterstown Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Carroll Roberts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche V. Roberts
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 2, 1876

8. AGE: Years	Months	Days	If less than one day
68	5	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Chief Clerk to President
11. Industry or business B & O RR

FATHER
12. Name Charles E. Roberts
13. Birthplace Calvert County, Md.

MOTHER
14. Maiden Name Anne M. Talbott
15. Birthplace Talbot County, Md.

16 (a) Informant Mrs. Blanche V. Roberts
(b) Address 3012 Reisterstown Road

17 (a) Burial (b) Date thereof Oct. 4, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Woodlawn, Md.

18 (a) Funeral director J. Willis Lamonan
(b) Address 4510 Liberty Heights Ave.
Harry Lee Williams, Mgr

19 (a) (b)
(Date received by Registrar) Registrar

OCT 3 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1 1944, at 7.05P M

21. I certify that death occurred on the date above stated, that I attended deceased from May 1 1944 to Oct 1 1944
and that I last saw h. im alive on Sept 1944

Immediate cause of death Bronchial Pneumonia 2 days — Duration

Due to cirrhosis of liver ? —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide XX
(b) Date of occurrence X at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R D Kepler M. D.
Address Wentworth Apts Apt. Date signed 10-2-44

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√830

G21259 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1703 E. 29th St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9/10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1703 E. 29th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah F. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1st 1859

8. AGE: Years	Months	Days	If less than one day
85	1	2	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER 12. Name Horsey Burrows
13. Birthplace Md.

MOTHER 14. Maiden Name Mary E. Mitchell
15. Birthplace Md.

16 (a) Informant Mrs. Thomas A. Mobberley
(b) Address 1703 E. 29th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/44 (month) (day) (year)
(c) Cemetery or crematory Easton Cem.
Location Easton Md.

18 (a) Funeral director John F Hemmpne
(b) Address 715 Light St.

19 (a) OCT 7 1944 (b) By registrar Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3rd 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944, to Oct 3 1944, and that I last saw her alive on Sept 30 1944.

Immediate cause of death	Duration
Due to Cerebral Hemorrhage	
Due to Arteri Sclerosis	
Other Conditions Mental depression Due to arteri sclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac T. Sabin M. D.
Address 823 N. Wash St. Date signed 10/3/44

G21260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 N

G21260

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Baltimore Maryland

(c) Hospital or institution: West Baltimore General Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 1202 Frankelntown Road

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Joseph Theodore Jackson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife none

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/1905

8. AGE: Years	Months	Days	If less than one day
39	8	9	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Porter

11. Industry or business Filberts Almagamine

FATHER

12. Name unobtainable

13. Birthplace

MOTHER

14. Maiden Name Ella Jackson

15. Birthplace Md.

16 (a) Informant Ella Jackson

(b) Address 1202 Franklintown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location Md.

18 (a) Funeral director Jos. H. Kelson

(b) Address 1305 Pennsylvania Ave

19 (a) OCT 4 1944 (Date rec'd, registered) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3rd 1944, at 8:20 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)

by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Syphilitic Aortitis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard A. Mulligan M.D. Medical Examiner.

Date signed October 3, 1944

VS 151

G21261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 940

G21261
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument and Patterson
(c) Hospital or institution: Sinai Hospital of Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2008 BROOKFIELD AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Gouline

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Rachael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years	Months	Days	If less than one day
69			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation President
11. Industry or business Central Building Supply

FATHER
12. Name Morris -
13. Birthplace Russia

MOTHER
14. Maiden Name Hanta Blume -
15. Birthplace Russia.

16 (a) Informant Rachel Gouline
(b) Address 2008 Brookfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jos Lewis Inc
(b) Address 1398 E. Balto St

19 (a) Date rec'd by reg. 10-4-1944 (b) Filed Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1944, at 3:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1944 to 10/4 1944 and that I last saw him alive on 10/4 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Myocardial infarction	
Due to Coronary occlusion	
Other Conditions Generalized arteriosclerosis. Bronchopneumonia	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Abrams M. D.
Address Sinai Hosp. Date signed 10/5/1944

G21262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V183

G21262 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D-O-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 135 N. High St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Bullock

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-09-9027

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Rosie Bullock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15 - 1896

8. AGE: Years	Months	Days	If less than one day
48	3	18	hr. min.

9. Birthplace Longshoremens Va
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Betty Low
15. Birthplace ?

16 (a) Informant Rosie Bullock
(b) Address 1122 Thompson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. A. County Md

18 (a) Funeral director Joseph G. Locke
(b) Address 1326 N. Central Ave

19 (a) (Date rec'd by registrar) (b) (Registrar)

VS OCT 4 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION 12:45

20. DATE OF DEATH October 3, 1944, at A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy (Autopsy, Inspection or Inquiry), Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1 P.M Oct. 2, 1944 M.
(b) Where did injury occur? Pier 4 Pratt Street
(c) Did injury occur at home, on farm, industrial place, in public place? Place of employment While at work? Yes
(d) Means of injury fell into Harbor.

23. Signature Howard J. Walters M.D.
Medical Examiner.
Date signed October 3 1944

G21263
46256

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

461

G21263
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 N. Spring Ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mamie Smith

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Edgar

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-13-08 age 36

8. AGE: Years 46 | Months 6 | Days 16 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife.

11. Industry or business

FATHER
12. Name James Gant.
13. Birthplace ?

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 4/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Rotha A. Elliott & Dept
(b) Address 1227 N. Caroline St.

19 OCT 4 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1944 at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 23 1944 to Sept 29 1944 and that I last saw him alive on Sept. 29 1944

Immediate cause of death	Duration
Lymphosarcoma infiltrating intestinal tract with hemorrhage	
Due to	
Due to	
Other Conditions Secondary Anemia (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Cosman M.D.
Address J. Hopkins Date signed 9-30-44

G21264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 13 W

G21264 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 729 S. Ann St - D.O.A.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 729 S. Ann St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Roman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Walenty Roman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation House

11. Industry or business

FATHER
12. Name Joseph Wisniewski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Walenty Roman
(b) Address 729 S. Ann Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street Huntington Williams, Inc.

19 (a) (Date received by registrar) 1944 Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/2 1944, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-Renal Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Chester F. Schmidt M.D. Medical Examiner.
Date signed 10/2/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

C21265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 70 C

C21265 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 d a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glenarm
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Millard W. Class

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1st 1928

8. AGE: Years 15 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Co. Maryland (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name J. George Class
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Ora V. Smith
15. Birthplace Baltimore, Maryland

16 (a) Informant Mr. J. George Class
(b) Address Glenarm Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5. 1944 (month) (day) (year)
(c) Cemetery or crematory St. Johns Lutheran
Location Parkville, Maryland

18 (a) Funeral director Lussky Memorial Home
(b) Address 7401 Belair Road

19 (a) OCT 4 1944 (Date received by registrar) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1944, at 11 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured skull. Fracture and dislocation of right arm. Multiple lacerations and brush burns.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10 P.M. at Oct. 2, 1944 Balto. Co. Md.
(b) Where did injury occur? Mt. Vista Road and Long Valley Farm.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Passenger in car which turned over.

23. Signature Thomas P. Wadsworth M.D. Medical Examiner.
Date signed Oct. 3, 1944.

VS 151

G21266

G21266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4103 Springdale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLOTTE H. HANCOCK

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Scott Ridgeley Hancock
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1852

8. AGE: Years	Months	Days	If less than one day
91	11	8	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Archibald Cook
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Margaret E. Turner
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. J. Harry Dittman
(b) Address 4103 Springdale Ave.

17 (a) Burial (b) Date thereof 10/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williamsburg Md

VS 150
OCT 4 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2, 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944, to Oct 2 1944, and that I last saw h.e.w. alive on Oct 1st 1944.

Immediate cause of death
Pneumonia
+ Influenza
Due to Acute age

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
3 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. C. Simmons M. D.
Address 4509 Liberty Hts Date signed Oct 3

G21467

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1310 G21467 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 N. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 N. Washington St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES J. REDDISH

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 212-03-7066

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rena G.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 24, 1881

8. AGE: Years	Months	Days	If less than one day
62	9	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Office Manager
11. Industry or business O. E. Wentworth

FATHER
12. Name Charles W. Reddish
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Williams Reddish
15. Birthplace Maryland

16 (a) Informant Mrs. Rena G. Reddish
(b) Address 1805 N. Washington St. 13

17 (a) Burial (b) Date thereof 10/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar
OCT 4 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1944, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Oct 1 1944
and that I last saw him alive on Sept 29 1944.

Immediate cause of death: Coronary Thrombosis - Cardio-vascular-Renal
Due to Arteriosclerosis -

Duration
Oct 1944
3 hrs
3 yrs -

Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Louis F. Krumreen M. D.
Address 722 N. Linwood Ave Date signed Oct 4/44

G21268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 N

G21268 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5428 Narcissus Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5428 Narcissus Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME CHARLES HENRY GRIFFITH HUNGERFORD

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary D. Hungerford
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 19, 1861

8. AGE: Years: 83 | Months: 5 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Watchman - retired
11. Industry or business: New York Times

FATHER
12. Name: Hungerford
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Griffith
15. Birthplace: Baltimore, Md.

16 (a) Informant: Mrs. Helen Bier,
(b) Address: 5428 Narcissus Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/4/44 (month) (day) (year)
(c) Cemetery or crematory: Greenmount Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 OCT 4

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1, 1944, at 7:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Oct 1st 1944 and that I last saw him alive on Oct 1st 1944

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to Hypertension	2 years
Due to Arterio Sclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. C. Samuels M. D.
Address 4509 Sanford Rd. Date signed Oct 3

G21269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G21269
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4706 Keswick Road
(c) Hospital or institution: at home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 0 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4706 Keswick Rd
(If rural give location)
(e) Citizen of foreign country? —No— (Yes or No)
If yes, name country

3 (a) FULL NAME Ruth DeWitt

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles DeWitt
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 5 1865

8. AGE: Years 79 | Months 4 | Days 27 | If less than one day: hr. ... min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name William March
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Stiltz
15. Birthplace Md.

16 (a) Informant Mrs Dorothy D. Adt (daughter)
(b) Address 4706 Keswick Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 4/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Av - Balto.

18 (a) Funeral director Sherwood Memorial Co.
(b) Address 1082 Mont Ave.

19 (a) ... (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 4 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1944, at 4-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 9 1944 to Oct. 2 1944, and that I last saw her alive on Oct. 2 1944

	Duration
Immediate cause of death: Acute Myocardial Failure	2 days
Due to: Acute Arteriosclerosis	14 years
Due to: —	
Other Conditions: —	

(Include pregnancy within 3 months of death)
Date of operation: —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Gibson Porter
Address 4822 Roland Ave Date signed 10/2/44 (M. D.)

G21270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G21270

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address E. 33rd St.
(c) Hospital or institution:
The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 89yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Esplanade Apartments
Entour Place & Brooks Lane No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Carrie Rosenthal Kann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mr Samuel S. Kann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 22, 1855

8. AGE: Years 89 | Months 8 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Mr Marcus Rosenthal
13. Birthplace Germany

MOTHER
14. Maiden Name Fannie Steiner
15. Birthplace Germany

16 (a) Informant Mr Harry Lazarus
(b) Address Temple Gardens Apt 507

17 (a) Burial (b) Date thereof 10/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Balto. Hebrew
Location Balto. Md.

18 (a) Funeral Chapel Interment - Sam
(b) Address 902 Entour Place

19 (a) (b) Huntington Williams, M.D.
Date (Registrar)
OCT 4 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1944, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 1, 1944 to October 3, 1944 and that I last saw her alive on October 3, 1944

Immediate cause of death: Cardiac Failure — Duration: 3 days

Due to: Arterio-sclerotic cardio-vascular disease — Duration: 9 yrs

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. Warfield M.D.
Address Union Memorial Hosp. Date signed 10-5-44

G21271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G21271 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 4319 Hamilton Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Louisa Bonnett Bonnett

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 4 1869

8. AGE: Years 75 | Months 5 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation
11. Industry or business At Home

FATHER
12. Name John Bonnett
13. Birthplace France

MOTHER
14. Maiden Name Gertrude Speck
15. Birthplace Bavaria

16 (a) Informant Edwin Reese
(b) Address 4319 Hamilton Ave

17 (a) Burial (b) Date thereof Oct 5 42
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location City

18 (a) Funeral director Sellers & General Home
(b) Address 2004 E Baltimore St

19 (a) OCT 4 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1944, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/9 1944, to 10/2 1944, and that I last saw he alive on 10/2 1944.

Immediate cause of death Hypostatic pneumonia — Duration

Due to Fracture of Hospital left Femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/6
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July 15 1944 at 7 P.M.
(c) Where did injury occur? 1736 E. 28th Street
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No
(Specify type of place)
(e) Means of injury Fall down a flight of steps

23. Signature Wm. H. E. Wallace M.D.
Address 1400 N. Caroline St Date signed 10/2/44

For Wm. H. Wollenweber, by Howard J. Wallace, M.D.

G21272

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21272

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address #818 N. Bentalou
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. #818 N. Bentalou.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie M. Clark

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife late Zackery T. Clark
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 10, 1866

8. AGE: Years	Months	Days	If less than one day
78	1	22	23 hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)
10. Usual Occupation housework
11. Industry or business at home

FATHER
12. Name William Mitchell
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Sarah Dennison
15. Birthplace Va

16 (a) Informant Mrs Mary M. Weidman
(b) Address 818 N. Bentalou St

17 (a) burial (b) Date thereof 10/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Longwood & Edmondson Ave

18 (a) Funeral director John J. Cowan & Son
(b) Address 901-3 Hollins St

19 (a) OCT 4 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1944, at 2.30 A.M.

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained by said Inquiry find that said deceased came to natural death on the day stated above.
(Autopsy or Inquiry)

Immediate cause of death	Duration
Coronary Thrombosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hugh B. McNally M.D.
Medical Examiner.
Date signed 10/5/44

G21273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21273

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 101 S. Carrollton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 101 S. Carrollton Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Lillian M. Mahoney

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	married

6 (b) Name of husband or wife Joseph W. Mahoney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1894

8. AGE: Years	Months	Days	If less than one day
50	6	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Home, wife
11. Industry or business at home

FATHER
12. Name William J. Martin
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emma Detering
15. Birthplace Baltimore Md.

16 (a) Informant Mr. Joseph W. Mahoney
(b) Address 101 S. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd

18 (a) Funeral director John J. Gowan & Son
(b) Address 1625 Hollins St.

19 (a) OCT 6 1944 (Date rec'd by registrar) (b) Thurlington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2nd 1944, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944, to Oct. 2 1944, and that I last saw alive on Oct. 1 1944.

Immediate cause of death Coronary Thrombosis — Duration 1 week
Due to
Due to
Other Conditions Influenza — 4 days
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. J. Mara M. D.
Address 116 Cathedral St. Date signed 10-6-44

G21274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G21274
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1416 W. Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Jenkins.

3 (b) If veteran, name war None

3 (c) Social Security Account No. 220-10-2650

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Lottie Clark Jenkins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1886

8. AGE: Years 58 | Months 2 | Days 25 | If less than one day hr. min.

9. Birthplace Frostburg Md
(Town, county, and state)

10. Usual Occupation Guard

11. Industry or business Canton R.R.

FATHER 12. Name John Jenkins

13. Birthplace Wales

MOTHER 14. Maiden Name Unknown

15. Birthplace Unknown

16 (a) Informant Wilbert T. Jenkins

(b) Address 608 Park Ave. Johnstown Penna

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1944 (month) (day) (year)

(c) Cemetery or crematory Frostburg Md
Location

18 (a) Funeral director Robt C & M. Walter

(b) Address Pratt & Stricker Sts

19 (a) (Date rec'd by Registrar) OCT 4 1944 (b) Huntington W. Va. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1944 at 615 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 1944 to 10/3 1944, and that I last saw him alive on 10/3 1944.

Immediate cause of death: Cardiac Failure — Duration

Due to: myocardial disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Rawlett, Jr. M. D.

Address St. Agnes Hosp Date signed 10/3/44

G21275

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21275 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts.
(c) Hospital or institution: Maryland General Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3309 Yolanda Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Edward Freeman, Sr.

3 (b) If veteran, name of war

3 (c) Social Security Account No. 212-10-1786

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie G. Freeman
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1884

8. AGE: Years	Months	Days	If less than one day
59	11	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name James E. Freeman
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary A. Harris
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Nellie G. Freeman
(b) Address 3609 Yolando Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10- 5- 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) [illegible] (Date received by registrar) 1944 Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1944, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944, to 10/2 1944, and that I last saw h[illegible] alive on 10/1 1944.

Immediate cause of death Pulmonary Edema — Duration

Due to Arteriosclerotic Cardio Vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland General Hosp. Date signed 10/3/44

G21276 BALTIMORE CITY HEALTH DEPARTMENT G21276
CERTIFICATE OF DEATH
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 41 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1806 West Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LUDWIK or LUDWIG RAUF

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 214--03-1530

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Minnie Krauza Rauf
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept. 6, 1882

8. AGE: Years 62 | Months 0 | Days 26 | If less than one day ____ hr. ____ min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Balto. Pure Rye Dist. Co.

FATHER
12. Name Carl Rauf
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Mrs. Minnie Rauf
(b) Address 1806 West Avenue

17 (a) Burial (b) Date thereof 10- 6-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) OCT 4 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1944, at 4 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH fracture of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10/1/44 at 5:30 P. M.
(b) Where did injury occur Fuller Paint Road near Augusta Ave., Dundalk
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Auto

23. Signature Howard J. Mullen M.D.
Medical Examiner.
Date signed Oct. 3, 1944.

G21277

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

115C ✓ G21277 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (~~yrs., mos.~~, or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 18
(If outside city or town limits, write RURAL and give town)
(d) Street No. 933 E 41st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barbara Jean Gladkowski

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married, widowed,~~ or divorced.
F	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7 | 2 | 39

8. AGE: Years	Months	Days	If less than one day
5	3	1	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Edward Gladkowski
13. Birthplace Md.

MOTHER
14. Maiden Name Nawrzymiak
15. Birthplace Md.

16 (a) Informant Father
(b) Address 933 E 41st St.

17 (a) Burial (b) Date thereof 10-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location

18 (a) Funeral director Mario Falkowski
(b) Address 1000 S. Kenwood ave

19 (a) (b) Huntington Millington, Md.
(Date rec'd by registrar)

OCT 4 1944 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1944, at 4 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944, to 10/3 1944, and that I last saw her alive on 10/3 1944.

Immediate cause of death	Duration
Hemorrhage, acute	
Due to T & A	
Due to	
Other Conditions Aplastic Anemia	

(Include pregnancy within 3 months of death)
Date of operation 9/22
Major findings of operation: Hypertrophied tonsils
of autopsy: None

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature P A Cowley M. D.
Address University Hospital Date signed 10/3/44

COWLEY

G21278

JO #39912

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21278
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Rural Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wise Ave., Dundalk, Box 92
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Athan or Arthur Pearson

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19, 1944

8. AGE: Years	Months	Days	If less than one day
----	-3-	12	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Baby
11. Industry or business

FATHER
12. Name Leroy Pearson
13. Birthplace North Carolina

MOTHER
14. Maiden Name Esther Smith
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-4-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) OCT 4 1944 (Date rec'd by registrar)

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 1, 1944, at 1:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 22, 1944, to Oct. 1, 1944, and that I last saw him alive on Oct. 1, 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Malnutrition	
Due to Pertussis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ellis Feer M. D.
Address Baltimore City Hospitals Date signed 10-2-44

G21279 Steele

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21279

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lexington Apts., North Charles
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 82 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lexington Apts., North Charles 4.8
3918 N. Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Kate Steele

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1862

8. AGE: Years	Months	Days	If less than one day
82	9	19	4 hr. 0 min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Isaac Neusa Steele
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Rosa Nelson
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. M. Smith Pendleton
(b) Address R.F.D., Lutherville, Maryland

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

OCT 4 1944 (b) Registrar
(Date received) (Registrar)
Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1944, at 6:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw her alive on 19

Immediate cause of death	Duration
Heart failure	
Due to	
Due to	
Other Conditions Ca of tongue	

(Include pregnancy within 3 months of death)

Date of operation 9/12/44
Major findings of operation: Ca of tongue
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William H. Lyle M. D.
Address Union Memorial Hosp. Date signed 10/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

MARGIN RESERVED FOR BINDING

G21280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

47 dG21280 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 N.Glover St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 N.Glover St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J.Armeling

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife May Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec.16,1884

8. AGE: Years	Months	Days	If less than one day
59	9	15	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Guard Crown Cork &
11. Industry or business Seal Co.

FATHER
12. Name Henry Armeling
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Elizabeth Wagner
15. Birthplace Baltimore Md.

16 (a) Informant Wife
(b) Address 108 N.Glover St.

17 (a) Burial (b) Date thereof 10/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) OCT 4 1944
(Date rec'd by registrar)

Burial Permit Issued

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1st 1944 at 1230 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 9 1944, to Sept 30th 1944, and that I last saw h[illegible] alive on Sept 30th 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	24 hrs
Due to Carcinoma of Left Lung	?
Due to Metastasis in Brain	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H J Hamilton M.D.
Date signed Oct 3rd 1944

Burial Permit Issued Huntington for Williamsport Md. 100 N Mulberry by

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

D 21281 — 44 Gilmor 113 N Monroe St — 21281

BALTIMORE CITY HEALTH DEPARTMENT — Registered No.

CERTIFICATE OF DEATH 48a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Underline the correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1303 N Charles St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 N Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Lubon R Conroy

3 (b) If veteran, name war: W — 3 (c) Social Security Account No. none

4. Sex: Male — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1911

8. AGE: Years 33 | Months 6 | Days 1 | If less than one day: hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER — 12. Name Elijah A Hamon — 13. Birthplace Va

MOTHER — 14. Maiden Name Martha L Phillips — 15. Birthplace Va

16 (a) Informant Mr Frank J Conroy

(b) Address 1303 N Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Baltimore Md

18 (a) Funeral director Pellegrini Funeral Home

(b) Address 1217 Light St

19 (a) (Date received by registrar) (b) Hunting on Williamsburg Md

OCT 4 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1944 at 7 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 8 1943 to Oct 2 1944 and that I last saw h[illegible] alive on Oct 2 1944.

Immediate cause of death Inanition,

Malnutrition

Due to Carcinoma of Stomach

Due to

Other Conditions Hypertension

metastases

(Include pregnancy within 3 months of death)

Date of operation Exploratory 10/21/43

Major findings of operation: Carcinomatosis

of autopsy: 4/15/44

Duration
6 mo.
14 yr.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence — at — M

(c) Where did injury occur? —
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)

(e) Means of injury —

23. Signature Thomas A Gibson M.D.

Address 113 W. Monroe St. Date signed 10/3/44

G21282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94N

G21282 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Home for the Aged of the Methodist Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Avenue (If rural give location)
Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie May Foreman

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Joseph E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1872

8. AGE: Years	Months	Days	If less than one day
72	4	24	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Tweedle
13. Birthplace England

MOTHER
14. Maiden Name Sarah Ann Ward
15. Birthplace Maryland

16 (a) Informant Miriam A Cates
(b) Address 2211 Rogers Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18 (a) Funeral director Wilbur Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) (Date rec'd by registrar) (b) Huntington Wilson, Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1944, at 8:35 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally, M.D. Medical Examiner.
Date signed October 3, 1944.

G21283

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21283
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3829 Hanover St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3829 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Conrad Harle

3 (b) If veteran, name war: N
3 (c) Social Security Account No. 215-03-3465

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 23, 1881

8. AGE: Years 62 | Months 11 | Days 9 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Candy Maker
11. Industry or business Ice Cream

FATHER
12. Name Charles W. Harle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Louise Hargrove
15. Birthplace Phila, Penna

16 (a) Informant Robert C. Harle
(b) Address 3 Jeffery St Brooklyn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 1944 (month) (day) (year)
(c) Cemetery or crematory Adar-Hill
Location Anne Arundel County Md

18 (a) Funeral director Wm Cook Hoge
(b) Address 4 East Preston St Balto

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1944 at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1943 to Oct 2 1944, and that I last saw h. alive on Oct 2 1944.

Immediate cause of death	Duration
primary cancer of liver	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip W. Keister, M.D.
Address 302 Patapsco Av Date signed Oct. 3 '44 (M. D.)

Philip W. Keister

G21284

BALTIMORE CITY HEALTH DEPARTMENT G21284
CERTIFICATE OF DEATH 13 12 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 S. Schroeder
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 127 S. Schroeder (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isabelle Roe

3 (b) If veteran, name war W
3 (c) Social Security Account No. 0000

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband David
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/9/1873

8. AGE: Years 70 | Months 10 | Days 23 | If less than one day hr. min.

9. Birthplace West Virginia (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Plant Unk.
13. Birthplace Unknown

MOTHER
14. Maiden Name Mawdy ?
15. Birthplace West Virginia

16 (a) Informant David Roe
(b) Address 127 S. Schroeder

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1944 (month) (day) (year)
(c) Cemetery or crematory Odd-Hill
Location Baltimore Anne Arundel County

18 (a) Funeral director Wm. Carl Lee
(b) Address 1st Paul & Preston Balto

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1944, at 4:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Oct 2 1944, and that I last saw h alive on Oct 2 1944

Immediate cause of death — Duration
Exhaustion — 5 days
Due to Chronic Nephritis — Indefinite
Due to Natural Respiratory Failure — Indefinite
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. L. Thompson M. D.
Address 1644 Harford Date signed 10/3/44

Vol 150

G21285 Blue ✓ GR.1285

G21285

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

Registered No. .....

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Marylapd
(b) Street Address Hospital
(c) Hospital or institution: Sydenham Hosp. # 1 76
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs. 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 534 S. Oldham St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No) ✓
If yes, name country .....

3 (a) FULL NAME Dorothy Akers Blue 522416

3 (b) If veteran, name war — W | 3 (c) Social Security Account No. NONE

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife J. W. Blue
6 (c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) 4/25/1920

8. AGE: Years 24 | Months 5 | Days 8 | If less than one day ..... hr. ..... min.

9. Birthplace Roanoke, Va. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name B. T. Akers
13. Birthplace Floyd Co. Va.

MOTHER 14. Maiden Name Flora Blackwell
15. Birthplace Floyd Co. Va.

16 (a) Informant J. W. Blue
(b) Address 524 S. Oldham St.

17 Removal (b) Date thereof 10/4/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Roanoke
Location Roanoke Va.

18 (a) Funeral director Williams & Taylor
(b) Address 1217 Light St.

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

VS OCT 4 1944 Harrington

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1944, at 7:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1944, to 10/3 1944, and that I last saw h[illegible] alive on 10/3 1944.

Immediate cause of death Cerebral Thrombosis Collapse 1 day respiratory failure — Duration: 18 Days

Due to Poliomyelitis (bulbar type) — Duration: over

Due to .....

Other Conditions Pregnancy (7 mos) with Hemiplegia
(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: Same

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed Oct 3

G21286

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21286

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun Sts
(c) Hospital or institution:
Franklin Square Hosp W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-12-44 10-3-44
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2524 Barclay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J Schaefer SCHAEFER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No. 212-10-6796

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Amanda
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21st 1882

8. AGE: Years	Months	Days	If less than one day
62	3	12	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Brandel Ice Cream Co

FATHER
12. Name Michael J. Schaefer
13. Birthplace Md

MOTHER
14. Maiden Name Hockadel
15. Birthplace Md

16 (a) Informant Amanda Schaefer
(b) Address 2524 Barclay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 4 1944 (Registrar's signature) (b) Huntington Hiss Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-12 1944 to 10-3 1944, and that I last saw [deceased] alive on 10-3 1944

Immediate cause of death	Duration
Post operative shock	3 days
Due to Carcinoma of Stomach	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. Dennard M. D.
Address Medical Arts Bldg Signed

G21287
JO #24677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 930

G21287
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos 20 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 565 Oxford St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lecey Ridley

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife George (d)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
38	-?-	-?-	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ? (d)
13. Birthplace North Carolina

MOTHER
14. Maiden Name Etta Maddox
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md

18 (a) Funeral director Albert McElderry
(b) Address 545 McElderry St

19 (a) OCT 4 1944 (Date received by registrar) Registrar
Hattie Jos Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2, 1944, at 2:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3, 1943 to Oct. 2, 1944, and that I last saw her alive on Oct. 2, 1944.

Immediate cause of death	Duration
Bronchopneumonia	
Due to Cerebrovascular accident	1 wk.
Due to D.S. Hypertension	
Other Conditions Arteriosclerosis	
Heart disease	

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Elizabeth Woodward M. D.
Address Bay View City Hospitals Date signed 10-3-44

G21288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93N

G21288 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly written. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1216 N. Patterson Pk.Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 N. Patterson Park Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME William Conrad Cunzeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	widowed

6 (b) Name of husband or wife Florence E. Lloyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/14/1869

8. AGE: Years	Months	Days	If less than one day
75 yrs.	7	17	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Paul Cunzeman (son)
(b) Address 1216 N. Patterson Pk.Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

19 (a) (Date received by registrar) OCT 4 1944 Huntington Wi... Md.

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/1/44 19... at 5:15pm

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944, to Oct. 1944, and that I last saw h... alive on Oct 1 1944.

Immediate cause of death	Duration
Coronary Thrombosis	5 mos.
Due to Chronic Cardio vas. disease	8 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis J. Ayd M.D. M. D.
Address 2005 E. Lexington St Date signed 10/2/44

G21289

TH. 48699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 162 B

Registered No. G21289

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 26-12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Aged Home Owens Mills (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Olia Bennington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Lorenzo (D

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1870

8. AGE: Years 73 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Frederick, Maryland (Town, county, and state)

10. Usual Occupation Seamstress

11. Industry or business

FATHER
12. Name David William Young
13. Birthplace Frederick, Maryland

MOTHER
14. Maiden Name Mary Ellen Crouse
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Frederick Md.

18 (a) Funeral director Edna M. Evans Mrs
(b) Address 118 W. Fayette Rear Entrance

19 (a) OCT 4 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-2-44 at 8.30 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death: Cachexia / Anemia — Duration: ?

Due to: Senile debility / Arteriosclerosis — Duration: ?

Due to — Duration:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J M Phillips M. D.
Address Baltimore Md Date signed 10-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21290

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 36

G21290 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hospital RD.
(c) Hospital or institution: Sydenham Hosp. Del
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 Darley Ave (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME John Hawkins III

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT - 9 - 1937

8. AGE: Years 7 | Months | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Schoolboy

11. Industry or business —

FATHER
12. Name John W. Hawkins Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Hardesty
15. Birthplace Baltimore

16 (a) Informant Mother
(b) Address 1202 Darley Ave

17 (a) BURIAL (b) Date thereof 10/5/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location

18 (a) Funeral director Chas. J. Eggan & Son
(b) Address 118 N. Mt. Royal Ave

19 (a) (Date rec'd by registrar) OCT 4 1944 (b) Registrar Huntington Williams M.D.

VR 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1944, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1944, to 10/2 1944, and that I last saw him alive on 10/2 1944.

	Duration
Immediate cause of death Respiratory + Circulatory Failure	
Due to Bulbar Poliomyelitis	3 Days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.

Address Sydenham Hosp Date signed Oct 2 44

G21291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21291 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution:
University Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1039 W. Balto. St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Shannon — Mildred M. Shannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Caswell J. Shannon
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) May 17, 1890

8. AGE: Years	Months	Days	If less than one day
54	24	16	hr. min.

9. Birthplace Woodlawn Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Euler
13. Birthplace Woodlawn Maryland

MOTHER
14. Maiden Name Elizabeth Younger
15. Birthplace Woodlawn Maryland

16 (a) Informant Patient (previous to death)
(b) Address as above

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olive Cemetery
Location Randallstown, Md.

18 (a) Funeral director E. W. Pomeroy
(b) Address 1005 W. Baltimore St.

19 (a) OCT 4 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1944, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3. 2PM 1944, to Oct 3. 5PM 1944, and that I last saw her alive on Oct. 3 1944.

Immediate cause of death Apoplexy / Vascular accident — Duration 9 hrs.

Due to Cardiovascular disease

Due to Hypertension

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen A. Howe M. D.
Address University Hospital Date signed 10/3/44

G21292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

123

Registered No. G21292

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secour Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Penn. (b) County
(c) City or town Johnson City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 407 E. Unaka Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nanola Cunningham

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Geo. B.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 30 1903

8. AGE: Years 41 | Months 3 | Days 4 | If less than one day: hr. min.

9. Birthplace: Whitesburg Penn.
(Town, county, and state)

10. Usual Occupation: Teacher
11. Industry or business: Public School

FATHER
12. Name: Samuel Rhea
13. Birthplace: Penn

MOTHER
14. Maiden Name: Not known
15. Birthplace: "

16 (a) Informant: Mrs Geo B. Cunningham
(b) Address: Johnson City Penn

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/5/44
(month) (day) (year)

(c) Cemetery or crematory
Location: Johnson City Penn.

18 (a) Funeral director: William J. Dickner & Son
(b) Address: Bond & Boone Sts. Asst. for Williams, Md.

OCT 5 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1944, at 6 43 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/3 1944 to 10/4 1944 and that I last saw her alive on 10/4 1944.

Immediate cause of death: Diffuse Peritonitis — Duration: 15 days
Due to: Perforated Sigmoid — 15 days
Due to:
Other Conditions: Dilated Heart & Hypertension

(Include pregnancy within 3 months of death)

Date of operation: 9/4/44
Major findings of operation: Perforated Sigmoid
of autopsy: Diffuse Peritonitis & Acute Pyelitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Raymond Rongy M. D.
Address: Date signed 10/5/44

VS 150

G21293 BALTIMORE CITY HEALTH DEPARTMENT G21293

CERTIFICATE OF DEATH 83a

Registered No.

MARK'S RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4415 Pimlico Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4415 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hugo J. Gamse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Kate B.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Riga (Europe)
(Town, county, and state)

10. Usual Occupation

11. Industry or business Pharmacist

FATHER
12. Name Nochum Gamse
13. Birthplace Riga

MOTHER
14. Maiden Name Miriam Pass
15. Birthplace Riga

16 (a) Informant Mr Herman Gamse
(b) Address 2811 Allendale Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew Cem
Location Belair Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

OCT 5 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

10.00

20. DATE OF DEATH October 4 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-13 1944 to 10-4 1944 and that I last saw h.. alive on 10-4 1944

Immediate cause of death — Duration

Cerebral Hemorrhage

Due to arteriosclerosis — yrs.

Due to hypertension yrs.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Bernard Cohen M. D.

Address Marlborough apts Date signed 10-4-44

C21294

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. C21294

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Levindale Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sara Weitzman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed or divorced. Widowed

6 (b) Name of husband or wife Late Louis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 78 | Months - | Days - | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Dr F. E. Weitzman
(b) Address Annapolis Md

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Oct 5/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herzing Rum
Location Bowley Lane

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-26 W. North ave

19 (a) Date received by registrar OCT 5 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1944, at 1 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 17 1944, to Oct. 4 1944, and that I last saw h. alive on October 4 1944.

Immediate cause of death Cerebral hemorrage — Duration

Due to arteriosclerosis cerebri

Due to

Other Conditions Mitral insufficiency

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Adel for S. Goldstein M. D.
Address Levindale Home Date signed Oct. 4/44

G21295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 8/a

G21295 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hanover, Md.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Glenarm Md (Rural)
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Gaston Ellsworth Dillworth

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/3/1926

8. AGE: Years	Months	Days	If less than one day
18	2	30	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Farm work

11. Industry or business —

FATHER
12. Name Ernest Dillworth
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Bessie Riley
15. Birthplace Hanover Co. Va.

16 (a) Informant
(b) Address Glenarm, Md.

17 (a) Burial (b) Date thereof 10-6-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director L. J. Burch
(b) Address 5316 Harford Rd.

19 (a) (b) Registrar
Date Rec'd by OCT 5 1944
VS 150 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1944, at 7:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1944, to 10/3 1944, and that I last saw h.im alive on 10/2 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Staphylococcus Septicemia	6 Days
Staphylococcal Meningitis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Margaret H. D. Smith M. D.
Address Sydenham Hosp Date signed Oct 3

G21296

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

Registered No. G21296

(over)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 Lauretta Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits write RURAL and give town)
(d) Street No. 1931 Lauretta Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elgin Franklin JOHNSON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Baby

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 8, 1944

8. AGE: Years	Months	Days	If less than one day
		21	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Baby

11. Industry or business

FATHER
12. Name Amos JOHNSON
13. Birthplace Virginia

MOTHER
14. Maiden Name Rosie HAMMOND
15. Birthplace Baltimore, Md

16 (a) Informant Mrs Johnson
(b) Address 1931 Lauretta Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Harrington-Hillen, Inc.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 30, 1944 at 11 a-M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1944 to 9/30 1944 and that I last saw him alive on 9/30 1944

Immediate cause of death Bronchopneumonia — Duration 5 dys

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
(f) Signature Ralph W. Deaton M. D.
Address 426 W. Lafayette Ave Date signed 10/4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

VS 190

G21297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G21297 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland ✓

(b) Street address 714 St. Paul Street

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11

(e) Length of stay in Baltimore (yrs., mos., or days) 56 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore ✓

(If outside city or town limits, write RURAL and give town)

(d) Street No. 714 St. Paul Street

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME William Miller Elliott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna E. Elliott

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) May 8, 1863

8. AGE: Years 81 | Months 4 | Days 26 | If less than one day ....hr. ....min.

9. Birthplace Philadelphia - Pa

(Town, county and state)

10. Usual Occupation Architect

11. Industry or business

FATHER 12. Name William Miller Elliott

13. Birthplace

MOTHER 14. Maiden Name Nancy Ellis

15. Birthplace

16 (a) Informant Mrs. Wm. M. Elliott

(b) Address 714 St. Paul St

17 (a) Burial (b) Date thereof Oct 6 1944

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Elliott Family Burying Ground

Location Elliott City

18 (a) Funeral director Jenkins

(b) Address McCulloh St at Orchard

19 (a) (Date received by registrar) 1944 Registrar

Oct 5

Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1944, at 3A - M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1930, to Oct 4 1944, and that I last saw her alive on Oct 4 1944.

Immediate cause of death: Arterio-Sclerosis Myocarditis — Duration: Several

Due to:

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ....at ....M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature M. A. Heady

Address 1403 Parkview Date signed Oct 4 1944

G21298 Carey ✓ G21298

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 W. Read Street
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 86 yrs 3 mos 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 West Read Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Francis King Carey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife Anne Galbraith Carey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1858

8. AGE: Years 86 | Months 3 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county and state)

10. Usual Occupation Lawyer and Capitalist

11. Industry or business Owned and Lived Being Best Eyes

FATHER
12. Name Thomas Carey
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Susan Bond Kimber
15. Birthplace Philadelphia Penna.

16 (a) Informant Francis S. Carey
(b) Address Evergreen City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6 44 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Balto Md

18 (a) Funeral director Henry McKenrick Sons Co
(b) Address McCulloh & Richard Sts

19 (a) (Date rec'd by registrar) (b) Registrar

VS 1 OCT 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3 1944, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1942 to Oct 3 1944, and that I last saw h[illegible] alive on Oct 3 1944

Immediate cause of death: Arteriosclerosis Myocarditis — Duration: Gradual

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. T. Moody

Address 140 S Rockne Date signed Oct 5 44

The G21299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G21299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 mo.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Paine St. #11
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (Mary Ellen Arnold) (Helen H. Arnold)

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-05-9481

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	White	Widow

6 (b) Name of husband or wife Wm. H. Arnold.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1900

8. AGE: Years	Months	Days	If less than one day
44	5	3	hr. min.

9. Birthplace Boston, Mass.
(Town, county, and state)

10. Usual Occupation Rag Inspector

11. Industry or business J. Hopkins Hosp.

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ralph L. Gordon.
(b) Address 3525 Hickory Ave

17 (a) Burial (b) Date thereof Oct 6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~cemetery~~ St. Mary's
Location Hampden

18 (a) Funeral director Ehenowitz & Donovan
(b) Address 3615-17 Chestnut Ave

OCT 5 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/3 1944, at 1:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944, to 10/3 1944, and that I last saw her alive on 10/3 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	1 hr.
Due to Hypertensive Cardio Vascular Disease	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland General Hosp. Date signed 10/5/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G21300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

77c

Registered No. G21300

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 310 Forest Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mason

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1922

8. AGE: Years	Months	Days	If less than one day
22	7	20	hr. min.

9. Birthplace Portsmouth, Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stevens Lenear
13. Birthplace Charles Co., Md.

MOTHER
14. Maiden Name Rosalie Davenport
15. Birthplace Portsmouth, Virginia

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 327 N Schroeder St

19 (a) OCT 5 1944 (Date rec'd by registrar) Huntingtown, Md. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2 1944, at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Acute Alcoholism

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Walters M.D. Medical Examiner.
Date signed 10-2-44

G21301 ✓ G21301

G21301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12/a

Registered No. _____

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 635 Calhoun St
(c) Hospital or institution: 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) _____
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County _____
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 635 Calhoun St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country _____

3 (a) **FULL NAME** Amanda Frazier

3 (b) If veteran, name war _____ | 3 (c) Social Security Account No. _____

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Samuel Frazier

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec 25th 1867

8. AGE: Years 54 | Months 9 | Days 25 | If less than one day _____ hr. _____ min.

9. Birthplace S.C. (Charles) (Town, county, and state)

10. Usual Occupation _____

11. Industry or business _____

FATHER 12. Name Alexander Wright

13. Birthplace S.C.

MOTHER 14. Maiden Name Chanie

15. Birthplace _____

16 (a) Informant Susie Sanner

(b) Address 635 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus

Location _____

18 (a) Funeral director Mrs. Katie R. Williams

(b) Address 322 N. Schroeder St

19 (a) OCT 5 (Date rec'd by registrar) 1944 _____ Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3- 1944 at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/20 1944 to 10/3 1944, and that I last saw h[illegible] alive on 10/3 1944.

Immediate cause of death	Duration
Chronic Cardio-Vascular Renal	
Due to Disease (Hypertension)	6 mos.
Due to _____	
Other Conditions _____	

(Include pregnancy within 3 months of death)

Date of operation _____

Major findings of operation: _____

of autopsy: _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide _____
(b) Date of occurrence _____ at _____ M
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? _____ While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature H. A. Jackson

Address 600 Arlington Ave Date signed 10/4/44 M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARG RESERVED FOR BINDING

G21302

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21302 Registered No. 1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 941 Preis Al.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) L

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Pikesville Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 941 Preis Al.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME John W Meeks.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex 78

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Hazel Burton

6 (c) If alive, give age 9 years

7. Birth date of deceased (mo., day, yr.) Oct 11 - 1866

8. AGE: Years 77 78 | Months 11 | Days 20 | If less than one day ..... hr. ..... min.

9. Birthplace Clearmont Ind
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business —

FATHER
12. Name Benton Meeks.
13. Birthplace Md

MOTHER
14. Maiden Name Francis Hamilton
15. Birthplace Md.

16 (a) Informant Nannie Meeks
(b) Address 941 Preis Al.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St.

19 (a) OCT 5 (Date rec'd by reg'r) (b) 1944 Registrar
Transcript for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 1 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944, to Oct 1 1944, and that I last saw h— alive on Sept 29 1944.

	Duration
Immediate cause of death Cardiac Infarction	
Due to Hypertension	
Due to Nephritis	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Benjamin S. Tausch

Address 2317 Arunah Av Date signed 10/5/44
M. D.

G21303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

82

Registered No. G21303

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2952 Hanford Rd
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2952 Hanford Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Drager

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Henry Drager

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 18 1861

8. AGE: Years 83 | Months 1 | Days 23 15 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Christian Ruppert
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Fisher
15. Birthplace Germany

16 (a) Informant Miss Anna Ruppert
(b) Address 2952 Hanford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 44 (month) (day) (year)

(c) Cemetery or crematory Greenmount
Location Linden Lane, Hanford Rd

18 (a) Funeral director L. Heuman & Son
(b) Address 22 S. Broadway

19 (a) (b) Registrar

(State use'd by Registrar) OCT 5 1944

VS 188

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3, 1944, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15, 1944 to Oct. 3, 1944 and that I last saw her alive on Oct. 2, 1944

	Duration
Immediate cause of death: Coronary occlusion	8 days
Due to: Arteriosclerosis	4 yrs.
Due to:	
Other Conditions: Ataxic Paraplegia	4 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert J. Fitzgerald, M. D.
Address 1613 E. North Ave Date signed Oct 3-44

G21304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G21304
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or Institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 610 E. 41st. Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward J. Mulligan

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 12-1888

8. AGE: Years	Months	Days	If less than one day
56	8	20	hr. min.

9. Birthplace Balti. Md. (Town, county, and state)

10. Usual Occupation Electricis Asst.

11. Industry or business

FATHER 12. Name F. James. Mulligan
13. Birthplace Ireland.

MOTHER 14. Maiden Name M. Emma Langton
15. Birthplace Ireland

16 (a) Informant Sara Margaret Hill
(b) Address 610 E. 41 St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 6-44 (month) (day) (year)
(c) Cemetery or crematory St. Marys Govans
Location Homeland Ave.

18 (a) Funeral director John G. Modan
(b) Address 4201 Greenmount Ave

19 (a) (Date rec'd by registrar) (b) Registrar

VS 181 3 Huntington Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1944, at 6 A. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-2-44 at 12 noon M.
(b) Where did injury occur? Brown Hiss Co 11/2
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Fell from a loader

23. Signature Thomas J. Madden M.D. Medical Examiner.
Date signed October 3, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21305

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21305 Registered No. 131 B

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore Gen'l. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1600 Rosedale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ADOLPH G. WEINREICH

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-03-0664

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth F.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1873

8. AGE: Years	Months	Days	If less than one day
71	5	28	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business Fossetts

FATHER
12. Name Frederick Weinreich
13. Birthplace Germany

MOTHER
14. Maiden Name Theresa Trautman
15. Birthplace Germany

16 (a) Informant Mrs. Elizabeth F. Weinreich
(b) Address 1600 Rosedale St. 16

17 (a) Burial (b) Date thereof 10/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 (a) OCT 5 1944 (b)
(Date rec'd by registrar) Registrar

VS 180

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3 1944, at 4:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 10-3 1944.

Immediate cause of death: Uremia — Duration: 2

Due to: a chronic glomerular nephritis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: none

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [redacted] J. Taylor [redacted] M. D.

Address U. of B. G. H. Date signed 10-3-44

G21306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21306 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3025 Clifton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME IDA VIRGINIA WATKINS

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife William E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 17, 1854

8. AGE: Years	Months	Days	If less than one day
90	1	26	hr. min.

9. Birthplace Burlington, N. J.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Horace B. Price
13. Birthplace Burlington, N. J.

MOTHER
14. Maiden Name Margaret Shirley Tomlinson
15. Birthplace Bristol, Pa.

16 (a) Informant Miss Lola Watkins
(b) Address 3025 Clifton Ave.

17 (a) Burial (b) Date thereof 10/5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Balto., Md.

19 (a) OCT 5 1944 (b)
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1944 at 9:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1944 to Oct. 3 1944, and that I last saw h[illegible] alive on Sept 2° 1944.

Immediate cause of death	Duration
Cardiac Asthenia	2 days
Due to Arterial Sclerosis	10 years
Due to General Asthenia	6 Months
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Herbert E. Zapp M. D.
Address 3048 N. Howard St. Date signed 10/5/44

Huntington Williams, M.D.

G21307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1702

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 428 N. Eden Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Overton

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/2/1917

8. AGE: Years	Months	Days	If less than one day
27	2	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Teamster

11. Industry or business Huckster

FATHER
12. Name Lewis Forest
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Lillian Overton (mother)
15. Birthplace ~~428 N. Eden St.~~ Balto. Md.

16 (a) Informant Lillian Overton (mother)
(b) Address 428 N. Eden St.

17 (a) Burial (b) Date thereof 10/8/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l Pk.
Location Balto. County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512. Carrollton Ave.

19 (a) OCT 5 1944 (b)
(Date rec'd by reg.)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 3, 1944, at 12:15 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured skull.
Multiple bruises burns + lacerations
Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 12:05 A.M. Oct. 3, 1944
(b) Where did injury occur? Bond + Milliman Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by Auto.

23. Signature Howard J. Madden M.D.
Medical Examiner.
Date signed October 5 1944.

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21308 71553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21308 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 - 9months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4205 Lasalle Ave Le Salle
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Korthels

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 11th, 1870

8. AGE: Years	Months	Days	If less than one day
73	9	21	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name William (D
13. Birthplace Germany

MOTHER
14. Maiden Name Annie
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5 1944 (month) (day) (year)
(c) Cemetery or crematory Forest Lawn CHRISTIAN
Location Baltimore Md.

18 (a) Funeral director Thos. J. Wallace Inc.
(b) Address 1933 E. Oliver St.

19 (a) (Date received by registrar) OCT 5 1944 Huntington Williams M.D.

VB-180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 2nd, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1944 to 10-2 1944 and that I last saw him alive on 10-2 1944

Immediate cause of death	Duration
Arteriosclerotic Cardio vascular disease with hypertension and cerebral arterio. sclerosis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Arteriosclerotic Heart

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D. M. Rollins Jr Balt City Hosp M. D.
Date signed 10-5-44

JL - 9008 G21309 BALTIMORE CITY HEALTH DEPARTMENT G21309

CERTIFICATE OF DEATH 183a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 mins.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1713 Oldham St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nick Katistflokis or Nick Kaufflakas

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	?

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
70 ?	?	?	hr. min.

9. Birthplace ?
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records Clerk Mackie
(b) Address 4940 Eastern Ave. Baltimore Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5, 1944 (month) (day) (year)
(c) Cemetery or crematory Greek Cem. Evergreen
Location Baltimore, Md

18 (a) Funeral director D. L. Covington
(b) Address 21 W. 5 St.

19 (a) (Date rec'd by registrar) OCT 5 1944 (b) Registrar Huntington Nitha[illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 2 1944, at 4:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4:00 PM 10/2 1944, to 4:15 PM 10/2 1944, and that I last saw him alive on 10/2 1944.

Immediate cause of death	Duration
Cerebral vascular accident	?
Due to ?	
Due to ?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Roy Gibson Parrish
Address Baltimore City Hospital Date signed 10/3/44 M. D.

Approved by Medical Examiner

G21310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21310

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 269 N. Highland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife Virginia Rose

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 26, 1900

8. AGE: Years 44 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Middleburg Md.
(Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name James Morris
13. Birthplace

MOTHER
14. Maiden Name Armeda Merrill
15. Birthplace Frostburg Md

16 (a) Informant Thomas Morris
(b) Address 722 Barre St.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct 5 1944 (month) (day) (year)

(c) Cemetery or crematory St Peters & St Joseph
Location Govdiff. and Gaston

18 (a) Funeral director Wendell Clapper

(b) Address 312 S. Highland Ave

19 OCT 5 1944 (Date rec'd by registrar) Arlington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 1944, at 9:50 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Atelectasis of Lungs

Due to Mucus-purulent material in bronchi

Other Conditions Acute alcoholism

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Gretter M.D.
Medical Examiner.

Date signed October 2, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DG21311 69885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1476 Registered No. G21311

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1302 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

G 0 9960

3 (a) FULL NAME Myrtle Martin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Sidney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1910

8. AGE: Years	Months	Days	If less than one day
34	0	27 26	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Philloyd Tillman (D
13. Birthplace Va.

MOTHER
14. Maiden Name Rosa Carter (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6th/44 (month) (day) (year)
(c) Cemetery or crematory Gloucester Co, Va
Location
18 (a) Funeral director Elroy O Wilson
(b) Address
19 (a) DCT 5 1944 (Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3rd, 1944 19 , at 4.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/20 19 44, to 10/2 19 44, and that I last saw h.e.r alive on 10/2 19 44.

Immediate cause of death Pulmonary Embolism — Duration Hours

Due to Thrombosis of Pelvic vessels — Duration 3 days

Due to — Duration over

Other Conditions Hypertension HEART D. Pregnancy - 11 days post partum
(Include pregnancy within 3 months of death)

Date of operation 9/28/44 - Stillbirth

Major findings of operation: Normal post-partum pelvic viscera

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. B. Perry, Jr. M.D.
M. D.
Address Balto City Hosp Date signed 10/3/44

G21312 G21312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 518 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1548 Carswell
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓ 9d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1548 Carswell St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. Bateman

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	214-01-7144

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Laura A Bateman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10 1872

8. AGE: Years	Months	Days	If less than one day
72	3	24	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Retired Salesman
11. Industry or business Grocery -

FATHER
12. Name Henry Bateman
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Kasslowes ?
15. Birthplace Baltimore Md

16 (a) Informant Mrs Anita Hutching
(b) Address 1548 Carswell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1944 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location 3100 Old Frederick Rd

18 (a) Funeral director Elmer W. Coughlin & Son
(b) Address 924 E Baltimore St

19 (a) Filed by registrar OCT 9 1944 Huntington for Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1944, at 5 00 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1943 to Oct 4 1944, and that I last saw h... alive on Oct 3 1944

Immediate cause of death Coronary Embolism — Duration 1 hr

Due to Uremic Necrosis — 1 yr

Due to Carcinoma Prostate — 1 yr

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. S. A. Stevens M. D.
Address 2878 Harford Rd Date signed 10-11-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21313

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

REGISTERED G21313

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 627 E. Melville Ave
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 627 E. Melville (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph A. Eckenrode

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Catherine M. Eckenrode
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 2, 1872

8. AGE: Years 72 | Months 6 | Days 2 | If less than one day hr. min.

9. Birthplace Hanover Pa. (Town, county, and state)

10. Usual Occupation Ret. Sheet Metal

11. Industry or business

FATHER
12. Name Joseph Eckenrode
13. Birthplace Pa.

MOTHER
14. Maiden Name Josephine Althoff
15. Birthplace Pa.

16 (a) Informant Mrs. Catherine M. Eckenrode
(b) Address 627 E. Melville Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7/44 (month) (day), (year)
(c) Cemetery or crematory Mt. Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director Edwin W. Cullimore & Son
(b) Address 924 E. Eager St.

19 (a) OCT 5 1944 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th, 1944, at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-10-1944 to 10-4-1944, and that I last saw him alive on 10-3-1944.

	Duration
Immediate cause of death: Chronic nephritis	Unknown
Due to: Arteriosclerosis	Unknown
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. B. Seybert M. D.
Address 1807 Harford Rd Date signed 10-4-44

Huntington Williams, M.D.

G21314
461713

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21314
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Govans
(If outside city of town limits, write RURAL and give town)
(d) Street No. 355 - Oberle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Walker

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 2 08

8. AGE: Years	Months	Days	If less than one day
36 35			hr. min.

9. Birthplace N. J. (Town, county, and state)
10. Usual Occupation Laundry Helper
11. Industry or business

FATHER
12. Name Morris Borhart
13. Birthplace N. J.

MOTHER
14. Maiden Name Josephine ?
15. Birthplace N. J.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green City
Location Baltimore Md

18 (a) Funeral director Hellhorn & Graul
(b) Address 2417 E. Monument St.

19 (a) OCT 5 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 3 - 1944, at 10.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Oct - 3 1944, and that I last saw h[illegible] alive on Oct. 3 1944.

Immediate cause of death Intracranial Hemorrhage

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Oct 2, 1944

Major findings of operation: Fracture Intracranial Hemorrhage

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Chaulsons
Address Johns Hopkins Hospital Date signed 10/7/44

G21315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G21315

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wilson Point Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cecil Heade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-1-42

8. AGE: Years 2 | Months 2 | Days 3 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Jas C. Heade
13. Birthplace N.C.

MOTHER
14. Maiden Name E. J. Leahy
15. Birthplace N.C.

16 (a) Informant Record.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof Oct 5/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Statesville North Carolina

18 (a) Funeral director Harry J Connelly
(b) Address 412 Eastern Ave Essex

19 (a) Date rec'd OCT 5 1944 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4. 1944 at 2.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1944 to Oct 4 1944 and that I last saw Living alive on Oct 4 19 44

Immediate cause of death Brain Tumor (Retinoblastoma) — Duration 11 mo

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Owen M. Sexsmith M. D.
Address John Hopkins Hosp Date signed 10-5-44

OCT 5 1944

VS 150

G21316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21316

1706

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Calvert
(c) City or town Lusby
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Still

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6-22-30

8. AGE: Years 14 | Months 3 | Days 5 | If less than one day 13 hr. min.

9. Birthplace Tenn. (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Walter Still
13. Birthplace Tenn.

MOTHER
14. Maiden Name Virgie England
15. Birthplace Va

16 (a) Informant J.H.W. Record
(b) Address Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 7, 1944 (month) (day) (year)
(c) Cemetery or crematory St. Paul's
Location Lusby, Md

18 (a) Funeral director C. A. Hayhurst & Son
(b) Address Mutual, Md

19 (a) OCT 6 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

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MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5 1944, at 12 15 P M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Intracranial damage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-1- at 11 A M.
(b) Where did injury occur? State Rd Lusby Md
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fell from tail board - auto - Truck

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 10-5-44

G21317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21317 Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life (38 yrs)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 9
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2820 Bavenwood Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony John Phillips
3 (b) If veteran, name war —
3 (c) Social Security Account No.
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife Jeannette
6 (c) If alive, give age 40 years
7. Birth date of deceased (mo., day, yr.) 9-4-1906
8. AGE: Years 38 | Months 1 | Days | If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Grocery Clerk
11. Industry or business Grocery Store

FATHER
12. Name Anthony J Phillips
13. Birthplace Lithuania

MOTHER
14. Maiden Name Kate Pijuest
15. Birthplace Lithuania

16 (a) Informant Mrs Anthony J. Phillips
(b) Address 2820 Bavenwood Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 127 St. Paul St.
19 (a) (Date rec'd by registrar) OCT 6 1944 (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/4 1944 at 10:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9/17 1944 to 10/4 1944 and that I last saw h[illegible] alive on 10/4 1944
Immediate cause of death Cardio-Resp Failure — Duration 16 Hrs.
Due to Cardiac Failure — 3 wks.
Due to Chronic Nephritis — Unknown
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Chronic Nephritis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Charles F. O'Donnell M. D.
Address Mercy Hosp. Date signed 10-4-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. Especially important. Physicians: please write the causes of death clearly and legibly.

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BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21318 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Dennison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1826 N. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Virginia L. Carman

3 (b) If veteran, name war NH
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) ~~Single, married~~, widowed, or ~~divorced~~. Widowed
6 (b) Name of husband or ~~wife~~ Johnson Carman
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) about 1860
8. AGE: Years about 84 | Months | Days | If less than one day hr. min.
9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name (Unknown) Price
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant J. Wesley Carman
(b) Address 1826 N. Caroline St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date received by registrar) (b) Registrar Huntington Williams

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MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1944 at 5 00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 1941 to Oct. 1 1944 and that I last saw him alive on Oct. 4 1944.

Immediate cause of death: Hypertension & Arterio-sclerotic heart disease — Duration

Due to

Other Conditions Senility

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Krueger M. D.
Address 1402 E. Lanvale Date signed Oct. 5 44

G21319

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21319 Registered No.

CERTIFICATE OF DEATH 131B

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2103 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2103 E. Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Louisa Fritsche

3 (b) If veteran, name war: No | 3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert H. Fritsche
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18th 1871

8. AGE: Years 73 | Months 0 | Days 15 | If less than one day: hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Frederick Schleicher
13. Birthplace Unknown

MOTHER
14. Maiden Name Annie M. "
15. Birthplace "

16 (a) Informant Robert H. Fritsche
(b) Address 2103 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 6 1944 (Date rec'd by reg'r) (b) Registrar's signature Huddington Hitchcock, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3rd 1944, at 5:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 28 1944 to Oct 3 1944 and that I last saw her alive on Oct 3 1944.

Immediate cause of death: Uraemia — Duration: 5 days
Due to: Chronic Nephritis (Bright's Disease) — 10 yrs +
Due to:
Other Conditions: Hardening Arteries
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature David Schneider M. D.
Address 1101 N. Wilson Ave Date signed 10-5-44

David Schneider

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21320 47

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1309 Gorsuch Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1309 Gorsuch Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John A. Bruff, SR.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 239-09-5798

4. Sex	5. Color or race	6 (a) ~~Single~~, married, ~~widowed, or divorced~~
Male	White	Married

6 (b) Name of husband or ~~wife~~ Mary C. Bruff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31st 1902

8. AGE: Years	Months	Days	If less than one day
42	8	3	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Estimator - Mill Work
11. Industry or business Oettinger Lumber Co.

FATHER
12. Name John A. Bruff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary V. Smith
15. Birthplace Balto. Md.

16 (a) Informant Mary C. Bruff
(b) Address 1309 Gorsuch Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 S. Paul St.

19 (a) (Date received by registrar) (b) [illegible] Williams M.D.

OCT 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4th 1944; at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1943 to Oct 4th 1944 and that I last saw h~~im~~ alive on Oct 1st 1944

Immediate cause of death Carcinomatosis — Duration —

Due to Carcinoma of lung — Duration 2 years +

Due to — — —

Other Conditions — —

(Include pregnancy within 3 months of death)

Date of operation May 19 1943

Major findings of operation: Carcinoma of lung & upper lobe

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James P. Hamburger M. D.

Address 1207 Eutaw Pl Date signed Oct 5 44

(Over)

G21321 BALTIMORE CITY HEALTH DEPARTMENT G21321
CERTIFICATE OF DEATH 137a
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: Univ. Hosp.
(a) Baltimore City, Maryland
(b) Street address Lombard and Greene St.
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 15 20
(e) Length of stay in Baltimore (yrs., mos., or days) 16yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2606 Elsinore ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Nicholas O. Gibson

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Ethel Pittenbruse
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Mch 31. 1866

8. AGE: Years 78 | Months 6 | Days 4 | If less than one day 3 hr. min.

9. Birthplace Offord Md (City, county, and state)

10. Usual Occupation Clergyman

11. Industry or business M.E.

FATHER
12. Name Geo. H. Gibson
13. Birthplace Md

MOTHER
14. Maiden Name Margaret E. Sinclair
15. Birthplace Md.

16 (a) Informant Ethel P. Gibson
(b) Address 2606 Elsinore ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave

18 (a) Funeral director John Mitchell & Son
(b) Address 1960 Eutaw Place

19 (a) (Date rec'd by registrar) Huntington Williams, M.D.

VS 114

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 18 1944 to Oct 3 1944, and that I last saw him alive on Oct. 3 1944.

Immediate cause of death cardiac failure — Duration

Due to chronic myocarditis
bilateral hydronephrosis
Due to following transurethral prostatectomy

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Oct. 3, 1944
Major findings of operation: hypertrophied prostate gland
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M.D.
Address Univ. Hosp. Date signed 10/3/44

G21322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21322

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Oella
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Oella Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3.(a) FULL NAME Mark Hobson

3 (b) If veteran, name war

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Katie Hobson

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 6-2-75

8. AGE: Years	Months	Days	If less than one day
69	4	1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Hobson
13. Birthplace Md.

MOTHER
14. Maiden Name Barbara Reese
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10-7-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md

18 (a) Funeral director J.C. Nuginbochom
(b) Address Ellicott City Md.

19 (a) (Date rec'd by local registrar) (b) Registrar

OCT 6 1944 Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3. 1944, at 9.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1944, to Oct 3 1944, and that I last saw h.m alive on Oct. 3 1944.

Immediate cause of death	Duration
cardiac failure	
Due to cachexia	2 mos.
Due to carcinoma of Esophagus	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harris Hobson M.D.

Address Johns Hopkins Date signed 10/5/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21323 — 1944a — Registered G25533

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3401 N. Calvert St.
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3401 N. Calvert (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Calvin LeeFleet

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	215-03-1089

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lucille E. Fleet
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10-1882

8. AGE: Years	Months	Days	If less than one day
62	2 6	25	hr. min.

9. Birthplace Matthews, Va. (Town, county, and state)
10. Usual Occupation Vice-Pres.
11. Industry or business Standard Wholesale Phosphate Co.

FATHER
12. Name Walter Fleet
13. Birthplace Va.

MOTHER
14. Maiden Name Mollie O. Pitcher
15. Birthplace Md.

16 (a) Informant Mrs. Lucile E. Fleet
(b) Address 3401 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) OCT 6 1944 Washington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5 1944, at 6:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1944, to 10-5 1944, and that I last saw him alive on 10-4 1944.

Immediate cause of death	Duration
Coronary occlusion	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Acute dilatation of bladder

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lt. H. McCrum USN
Address U.S. General Hosp. Date signed 10-5-44
M. D.

G21324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21324 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Rd.
(c) Hospital or institution: Snyder Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2870 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carrie E Byron

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	215-10-5727

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Fem	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 18, 1880

8. AGE: Years	Months	Days	If less than one day
64	2	16	hr. min.

9. Birthplace Chestertown, Md. (Town, county, and state)
10. Usual Occupation Bookkeeper
11. Industry or business Kidd & Buckingham

FATHER
12. Name James Byron
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Elizabeth Hutchins
15. Birthplace Chestertown, Md.

16 (a) Informant Mrs. Georgia Downs
(b) Address 2868 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory Chester Cemetery.
Location Chestertown, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 6 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1944 at 5:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Oct 4 1944, and that I last saw h[illegible] alive on Oct 4 1944.

Immediate cause of death	Duration
Uraemia Convul	
Apon	
Due to Cerebral Hemorrh	
age	
Due to Hbn May 1944	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John A Evans M. D.
Address 62 W 40th St Date signed

G21325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G21325

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3404 Alto Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Alto Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CARRIE V. STEWART

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife William Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 27, 1877

8. AGE: Years 67 | Months 2 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name George Hugg
13. Birthplace Baltimore

MOTHER
14. Maiden Name Emma P. Webb
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elizabeth Ehlers
(b) Address 3404 Alto Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/6/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 6 1944

MEDICAL CERTIFICATION 8:00

20. DATE OF DEATH Oct. 4, 1944, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/19 1944 to 10/4 1944 and that I last saw h[illegible] alive on 10/4 1944

Immediate cause of death Lymphosarcoma — Duration 8 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert A. Ritter M.D.
Address 3401 Windsor Ave Date signed 10/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

G21326 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3420 W. Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3420 W. Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clara J. Weller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Joseph F. Weller Sr. 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 20, 1899.

8. AGE: Years 45 | Months 7 | Days 14 | If less than one day hr. min.

9. Birthplace Cambridge Dorchester Co., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name William T. Willis
13. Birthplace Dorchester Co. Md.

MOTHER 14. Maiden Name Mary E. Foxlee
15. Birthplace Dorchester Co. Md.

16 (a) Informant Joseph F. Weller Sr.
(b) Address 3420 W. Belvedere Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Loring Bayless
(b) Address 5005 Park Heights Ave.

19 (a) (Signature of local registrar) (b) Registrar

OCT 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1944, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944, to Oct 4 1944, and that I last saw her alive on Oct 3 1944.

Immediate cause of death	Duration
Bronchopneumonia	2 days
Heart Failure	
Due to Carcinoma of Breast	
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation April 17 - 1943
Major findings of operation: Carcinoma of Breast
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 5276 Park Heights Ave Date signed Oct 4 44

Huntington Williams, M.D.

G21327 BALTIMORE CITY HEALTH DEPARTMENT G21327
Registered No.

CERTIFICATE OF DEATH 1937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 661 Barre St - D.O.A
(c) Hospital or institution 21
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Scott St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cynthia Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C.	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1872

8. AGE: Years	Months	Days	If less than one day
65	3	25	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs C Richardson
(b) Address 711 Scott Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7, 1937 (month) (day) (year)
(c) Cemetery or crematory Mount Zion
Location Baltimore County

18 (a) Funeral director Joseph A Lisby
(b) Address 499 Mount Street

19 (a) (Date received by registrar) OCT 6 1937 Registrar
VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1937, at 8 00 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature Clinton L Tolbert M.D. Medical Examiner.
Date signed 10/6/37

Huntington Williams MD

G21328

G21328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 43a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. the cause's of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3041 Huntingdon Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3041 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry A. Hann

3 (b) If veteran, name war Spanish American | 3 (c) Social Security Account No. 213-03-8987

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Clara Wilson Hann

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14 1879

8. AGE: Years 65 | Months 8 | Days 20 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired R.R. Engineer

11. Industry or business Western Md. R.R.

FATHER
12. Name Francis Hann
13. Birthplace Md

MOTHER
14. Maiden Name Hanna Hunters
15. Birthplace

16 (a) Informant Mrs. Clara V. Hann
(b) Address 3041 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md.

18 (a) Funeral director MARTIN FAHEY & SONS
(b) Address 1827 N. North Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 6 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1944, at 11 39 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 4 1944, and that I last saw h. alive on Oct 4 1944

Immediate cause of death Cerebral Hemorrhage — Duration 14 hrs

Due to Hypertension Arteriosclerosis — 5 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? — (Specify type of place)
(e) Means of injury —

23. Signature Herbert M. Foster M. D.

Address 2824 St. Paul Date signed Oct 7, 44

32684
G21329

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

61

G21329
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2202 McCulloh (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace Quinn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jacob Quinn

6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 3-2-92

8. AGE: Years 49 | Months 7 | Days 1 | If less than one day ... hr. ... min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER 12. Name Isaac Hearns

13. Birthplace Md

MOTHER 14. Maiden Name Laura Fletcher

15. Birthplace Md

16 (a) Informant: Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) ... (Burial, cremation, or removal) (b) Date thereof Oct 6-44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Memorial Pk

Location Baltimore Maryland

18 (a) Funeral director Archibald B. Gaddis

(b) Address 2101 McCulloh Baltimore, Md.

19 (a) Filed OCT 6 1944 (b) Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3 1944 at 11 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased (from Aug 30 1944 to Oct 3 1944) and that I last saw her alive on Oct 3 1944

Immediate cause of death: Diabetes mellitus, uncontrolled — Duration: years

Due to: Gluteitis of buttocks — Duration: 3 months

Due to: — Duration:

Other Conditions ? Carcinoma — Duration:

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Cellulitis of buttocks

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Hatten

Address Johns Hopkins Hosp. Date signed 10/7/44

G21330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92c

G21330 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2210 E Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2210 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George E Butler

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-14-6080

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28th 1923

8. AGE: Years 21 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Electrician Helper

11. Industry or business

FATHER
12. Name Leo Butler
13. Birthplace Baltimore

MOTHER
14. Maiden Name Anna Brandt
15. Birthplace Baltimore

16 (a) Informant Anna Butler
(b) Address 2210 E Chase St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 5/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) (Date received by registrar) (b)

OCT 6 1944

Huntington Hollins

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1944, at 8:50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 9 1944 to Oct 3 1944 and that I last saw him alive on Oct 2 1944.

Immediate cause of death	Duration
Endocarditis + Valvular V Cent disease	
Due to Rheumatic Fever	5yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jacob Finkelstein M. D.
Address 1623 N. Market St. Date signed Oct 4/44

G21331

BALTIMORE CITY HEALTH DEPARTMENT

TH. 70585 CERTIFICATE OF DEATH 122a

G21331

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 -9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Fell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel J. Elliot

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race W

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1865

8. AGE: Years 78 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Joseph Elliot
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth O'Neil
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Oct. 7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Nat. Cath.
Location Balt. Frederick Rd.

18 (a) Funeral director John E. Moan
(b) Address 3018 E. Balto. St.

OCT 6 1944 (b) Huntington Williams, M.D.
(a) Date received (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3rd, 1944 at 9.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Oct 3 1944, and that I last saw h. alive on Oct 3 1944

Immediate cause of death: Bronchopneumonia. — Duration 2 da.
Strang. inguinal hernia — 15 min. [illegible]
Due to: Hypostasis & senility
Due to:

Other Conditions: Arterio-sclerosis & Gangrene of foot (Dec 1941)
(Include pregnancy within 3 months of death)
Date of operation: None (Refused)
Major findings of operation: R-29-41 - Amputation
1-6-43 - Arteriography
of autopsy: No autopsy.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Miller M. D.
Address East City Hosp Date signed 10-5-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21332

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G21332 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4401 Wrenwood Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4401 Wrenwood Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth S. Wood

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1877

8. AGE: Years	Months	Days	If less than one day
67	8	25	hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Samuel Morgan
13. Birthplace Annapolis Md.

MOTHER
14. Maiden Name Alberta Haslip
15. Birthplace Annapolis

16 (a) Informant Alberta Wood
(b) Address 4401 Wrenwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/7/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Mem.
Location Taylor Ave.

18 (a) Funeral director Clarence F. Hoffmann
(b) Address 1639 N. Broadway.

19 (a) OCT 6 1944 (Date received by registrar) (b) Registrar's signature Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4th. 1944, at 11:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2nd. 44 to Oct. 4th. 44 and that I last saw her alive on Oct. 4th. 1944.

Immediate cause of death	Duration
Lobar Pneumonia	36 hrs.
Due to LaGrippe	2 days
Due to ----	
Other Conditions Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jesse W. Morgan, M.D.
Address 401 E. 25th. St. Date signed 10/5/44

G21333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21333
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 937 E. Chase St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 E. Chase St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie G. Steinmeier

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-4534

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1888

8. AGE: Years	Months	Days	If less than one day
56 55	9 &	28	hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Erlangers, B.V.D.

FATHER
12. Name George F Steinmeier
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary R. Mooney
15. Birthplace Baltimore

16 (a) Informant Margaret Steinmeier
(b) Address 937 E. Chase St

17 (a) Burial (b) Date thereof Oct. 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Wiedefeld
(b) Address 914 Greenmount Ave

19 (a) (b)
(Date rec'd by registrar)

VS OCT 6 1944

Huntington Williams M.D. 1 E Read St

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6th 1944, at 830 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death: Duration
(a) Diabetes Mellitus ?
Due to (b) Arteriosclerosis years
Due to (c) Left Hemiplegia June 1944
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William R. Greaty M.D.
Date signed 10/6/44

G21334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G21334

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 622 S. Decker Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 622 S Decker Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Bachmann

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Caroline K

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Aug 6 1888

8. AGE: Years 56 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Penn.

FATHER
12. Name John Bachmann
13. Birthplace Balto.

MOTHER
14. Maiden Name Agnes Wright
15. Birthplace Balto.

16 (a) Informant Caroline K Bachmann
(b) Address 622 S. Decker Ave

17 (a) Balto (Burial, cremation, or removal) (b) Date thereof Oct 7 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Mart Wm Bruch
(b) Address 37 S Eutaw St

19 (a) OCT 6 1944 (Registrar's signature) Williams Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1944 at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 18 1944 to Oct 4 1944 and that I last saw h[illegible] alive on Oct 4 1944

Immediate cause of death Cardiovascular renal dis. — Duration 4 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leo S. Lefferty M. D.

Address 131 N. Patterson Pk. Date signed Oct 5 1944

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21335
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3001 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH A. MALOOLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex FEMALE | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. SINGLE

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 4 1867

8. AGE: Years 77 | Months 3 | Days 0 | If less than one day hr. min.

9. Birthplace BALTIMORE MD
(Town, county and state)

10. Usual Occupation RETIRED SCHOOL

11. Industry or business TEACHER

FATHER
12. Name THOMAS MALOOLY
13. Birthplace IRELAND

MOTHER
14. Maiden Name ELIZA SOMMERS
15. Birthplace IRELAND

16 (a) Informant MRS. MAMIE MALOOLY
(b) Address 506 E. CHASE ST

17 (a) BURIAL (b) Date thereof OCT. 7-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory CATHEDRAL
Location

18 (a) Funeral director Chas. J. Evans-Son
(b) Address 118 W. Mt. Royal Ave

19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 6 1944 Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1944, at 11:55 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24 1944, to 10/4 1944, and that I last saw her alive on 10/4 1944.

Immediate cause of death	Duration
Acute Respiratory Failure	
Due to Congestive Cardiac Failure	
Due to Renal insufficiency	
Other Conditions Diabetis Mellitus	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis T. Grumbine M. D.
Address Date signed

G21336

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124B

Registered No. G21336

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 771 W. Pratt St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore -
(If outside city or town limits, write RURAL and give town)
(d) Street No. 771 W. Pratt St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Dorsey.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Annie Dorsey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 6. 1892

8. AGE: Years 52 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore - Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (b) Date thereof 10-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Auburn

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) Date rec'd by reg. OCT 6 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 1. 1944 at 12-20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug-10 1944 to Oct-1. 1944 and that I last saw h[illegible] alive on 9/28 1944

Immediate cause of death Cirrhosis of Liver — Duration 4 mo.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature David Saunders M. D.
Address 1222 Lee N Date signed 10/6/44

G21337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G21337 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age in especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE + OLIVER ST.
(c) Hospital or institution:
ST JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town 1044 S. Charles St.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME BABY BOY BARNES

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) OCT. 1, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace BALTIMORE, MD.
(Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Hospital Record

(b) Address

17 (a) Burial (b) Date thereof 10-6-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Road

19 (a) (Signature of registrar) (b)

OCT 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 3 1944, at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 1 1944 to OCT. 3 1944, and that I last saw him alive on OCT. 3, 1944.

Immediate cause of death PREMATURITY — Duration 7 mos. Fetus

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury —

23. Signature M E Robertson M. D.

Address St. Joseph Hosp. Date signed 10/3/44

G21338 BALTIMORE CITY HEALTH DEPARTMENT ✓ G21338

CERTIFICATE OF DEATH 55E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5228 Linden Heights Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5228 Linden Heights Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martin Joseph Root,

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes Scheper Root
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Aug. 30, 1895

8. AGE: Years	Months	Days	If less than one day
49	1	3	....hr. ....min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation Broker
11. Industry or business Insurance

FATHER
12. Name Joseph Banks Root
13. Birthplace Maryland

MOTHER
14. Maiden Name H. A. Hellman,
15. Birthplace Maryland

16 (a) Informant Mrs. Agnes Root,
(b) Address 5228 Linden Heights Ave.

17 (a) Burial (b) Date thereof 10/7/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore City

18 (a) Funeral director C. Vernon Lemmon,
(b) Address 4411 Park Heights Ave.

19 (a) OCT 6 1944 Huntington Williams, M.D.
(Date rec'd by reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 3, 1944 19..., at ...M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-13-42 19..., to 10-3 1944 and that I last saw h[illegible] alive on 9-14 1943.

Immediate cause of death. Has been under treatment on W 7 Fincr (over)
Due to Carcinoma left thigh
Due to
Other Conditions General Marasmatosis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
About 4½ years.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at ...M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frederick Reiss M. D.
Address 1418 Eutaw Place. Date signed

G21339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G21339
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3118 Dillon St.
(c) Hospital or institution:
South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3118 Dillon St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Krug

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age 2 wks years

7. Birth date of deceased (mo., day, yr.) 9-19-44

8. AGE: ~~Years~~ | Months | Days: 19 | If less than one day: hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER
12. Name Milton Krug
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Baer
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 3118 Dillon St.

17 (a) BURIAL (b) Date thereof OCT. 9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LOUDON PARK
Location FREDERICK AVE.

18 (a) Funeral director Lilly and Gaelen Inc.
(b) Address 403 S. WOLFE ST.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 6 1944 Huntington Hollins M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6- 1944 at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4-1944 to 10-6-1944 and that I last saw h.er alive on 10-6-1944

Immediate cause of death	Duration
Pneumonia	2 wks.
Due to diarrhea & acidosis	
Due to	
Other Conditions thrush	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Ehrlich M. D.
Address 1213 Light St. Date signed 10-6-44

G21340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G21340
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 318 S. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 318 S. Fulton Ave.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Dora E. Stilling

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Joseph E.

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/24/1883

8. AGE: Years 60 Months 9 Days 11 If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town, county and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name James J. Haupt
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary E. Carey
15. Birthplace Maryland

16 (a) Informant Joseph E. Stilling
(b) Address 318 S. Fulton Ave.

17 (a) Burial (b) Date thereof 10-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director George E. Farley
(b) Address Fulton & Fayette Sts.
(c) OCT 6 1944 Washington Williams M.D.
(Date rec'd by registrar) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1944, at 1:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944, to 10/5 1944, and that I last saw h[illegible] alive on 10/5 1944.

Immediate cause of death	Duration
Acute cardiac dilatation	2 days
Due to Chronic myocarditis	
Due to C by perforation -	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A Calas M. D.
Address 4 N. Fulton Ave. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21341 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Do not abbreviate. Write out fully the name of the city, town, or county. Do not use ditto marks. Be sure to give the full name of the street and number. Do not write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Be sure to answer all questions. Be sure to give the correct age in years, months, days, hours, or minutes. Be sure to give the correct occupation. Be sure to give the correct industry or business. Be sure to give the correct birthplace. Be sure to give the correct maiden name. Be sure to give the correct informant. Be sure to give the correct address. Be sure to give the correct date of death. Be sure to give the correct cause of death. Be sure to give the correct duration. Be sure to give the correct physician. Be sure to give the correct signature. Be sure to give the correct date signed.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Rutland Ave.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 RUTLAND AVE (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MR. CHRISTINE STEINBACH

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife AUGUSTA STEINBACH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/23/1875

8. AGE: Years	Months	Days	If less than one day
69	4	11	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation BTC WEL. PEN.
11. Industry or business

FATHER 12. Name Gotlieb Steinbach
13. Birthplace Germany

MOTHER 14. Maiden Name Hannah —?
15. Birthplace Germany

16 (a) Informant Augusta C. Steinbach
(b) Address 1617 N Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-44 (month) (day) (year)
(c) Cemetery or crematory Meadowridge
Location Washington Blvd

18 (a) Funeral director Russell E Humphreys
(b) Address 1501 N. Broadway

19 OCT 7 1944 (Date rec'd by Registrar) Huntington White-Jones M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 4 1944 at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from SEPT. 16 1944, to OCT. 4 1944, and that I last saw HIM alive on OCT. 4 1944.

Immediate cause of death Cardiac failure
Due to Arteriosclerotic C.V. disease
Due to
Other Conditions Parkinsonism
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 10-7-44

G21342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G21342

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town New Windsor
(If outside city or town limits, write RURAL and give town)
(d) Street No. New Windsor, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Ellsworth Black

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Daisy Black

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Farm

FATHER
12. Name Levy Black
13. Birthplace Md.

MOTHER
14. Maiden Name Not
15. Birthplace Known

16 (a) Informant Mrs. Mary Stitely
(b) Address New Windsor Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9-1944 (month) (day) (year)

(c) Cemetery or crematory Westminster Cem.
Location Westminster, Md

18 (a) Funeral director H. H. Hartley & Sons
(b) Address Union Bridge & New Windsor Md

OCT 7 1944 (b) Huntington for Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1944, at 3:35 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1944, to 10/7 1944, and that I last saw h[illegible] alive on 10-7 1944.

Immediate cause of death Cardiac Failure — Duration 2 days

Due to Myocardial Damage

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Patrick Dodd M.D.
Address University Hospital Date signed 10/7/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21343

Bickhart

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH ✓170c

Registered No. G21343

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Trailer Camp - (If outside city or town limits, write RURAL and give town)
(d) Street No. Franklin Rd - Ritchie Highway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Patrick Bickhart

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8/27/30

8. AGE: Years 14 | Months 1 | Days 8 | If less than one day ____ hr. ____ min.

9. Birthplace Sunbury, Pa. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER
12. Name Clair Bickhart
13. Birthplace Sunbury, Pa.

MOTHER
14. Maiden Name Nettie Hollenger
15. Birthplace York, Pa.

16 (a) Informant Clair Bickhart
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 8-1944 (month) (day) (year)
(c) Cemetery or crematory
Location Selinsgrove Pa.

18 (a) Funeral director A. Lee Adee
(b) Address 1644 York Road.

19 (a) OCT 7 1944 (Date rec'd by Registrar) (b) Huntington Mills Registrar M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-1944, at 8 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured Cervical & Lumbar vertebrae; Ruptured Spleen (Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: A.A.C.
(a) Date of injury 10-5-44 at 7.40 P M.
(b) Where did injury occur? Light St. Rd. - Ritchie Highway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Wheeldon M.D. Medical Examiner.
Date signed 10-6-44

(over)

G21344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 70

G21344 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1709 Argyle ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alvin Jerome Bailey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 8 - 1943

8. AGE: Years 1 | Months 1 | Days | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Frank H Bailey
13. Birthplace Va

MOTHER
14. Maiden name Mildred Mathews
15. Birthplace Md

16 (a) Informant Frank H Bailey
(b) Address 1709 Argyle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 7 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jenkins
(b) Address 916 Pennsylvania ave

DCT 7 1944 (b) Date rec'd by Local Registrar — Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1944, at 3 p.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1944, to Oct 5 1944, and that I last saw him alive on Oct 5 1944.

Immediate cause of death	Duration
Malnutrition	
Secondary Anemia	
Due to	
Due to	
Other Conditions Probable Rickets	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Banfield M.D.
Address Glenarden Md Date signed 10/6/44

MARG[illegible] RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 61

G21345 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 615 Brookwood Road
(c) Hospital or institution:

28 - 4

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 615 Brookwood Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Owen Thatcher Hall

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Orie Ryan Hall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1881

8. AGE: Years 63 | Months 8 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Owner
11. Industry or business Electrical Motor Business

FATHER
12. Name Sheppard Hall
13. Birthplace Maryland

MOTHER
14. Maiden Name Hester Thatcher
15. Birthplace Maryland

16 (a) Informant Mrs. Orie Hall
(b) Address 615 Brookwood Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director George Beyer Jr.
(b) Address 1512 Holl[illegible]

19 (a) (Date rec'd by Registrar) (b) [illegible]ington Williams Registrar

OCT 7 1944

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1944 at 11:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from March 3, 1944 to Oct. 5, 1944 and that I last saw him alive on Oct. 5, 1944

	Duration
Immediate cause of death: Cerebral Embolism	15 min.
Due to: Chronic Myocarditis	2 yrs.
Due to:	
Other Conditions: Diabetes Mellitus (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George A. Kupp
3030 Edmondson Ave. Address
10/7/44 Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

69113 BS 107 G21346 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: Baltimore City Hospitals 18
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) 2
(d) Street No. 1080 West Fairmount Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lela Carroll

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-10 1912

8. AGE: Years 32 ? | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Frank Carroll
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Florence Burn
15. Birthplace Balto. Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Wilson

18 (a) Funeral director Miss Hattie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) (b) Registrar
OCT 7 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 4 1944, at 2:10AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7-22 1944, to 10-4 1944, and that I last saw her alive on October 3, 1944.

Immediate cause of death	Duration
Uremia	9
Bronchopneumonia	4
Due to Pemphigus Vulgaris	4 mos
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. M. Stillman Jr.
Address Balt. City Hosp. Date signed 10-9-44 M. D.

G21347 MOULTON

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21347 Registered No. 1380

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1083 W Fayette St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1083 W Fayette St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Charles Moulton

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-9123

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1900

8. AGE: Years	Months	Days	If less than one day
44	10	11	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

MOTHER / FATHER

12. Name Charles Moulton

13. Birthplace Ireland to Va

14. Maiden Name Bettie Runyon

15. Birthplace Ireland to Va

16 (a) Informant Bettie Moulton

(b) Address 1083 W Fayette St

17 (a) Burial (b) Date thereof Oct 8, 19 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Zion

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 322 N Schroeder St

19 (a) Filed by registrar OCT 7 1944 Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 3 1944 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Oct 3 1944 and that I last saw him alive on Oct 3 1944

Immediate cause of death	Duration
Pulmonary tuberculosis	4 mo.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William H. Watts

Address 515 Walbrook Ave Date signed 10/4/44

G21348 Thompson

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21348 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 N. Arlington Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 N. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Thompson (Malinda)
3 (b) If veteran, name war (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem	Col	Widow

6 (b) Name of husband or wife Joseph
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-12-1880

8. AGE: Years	Months	Days	If less than one day
63	10	22	hr. min.

9. Birthplace Northumberland Co-Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Father Unknown
13. Birthplace Va.

MOTHER
14. Maiden Name
15. Birthplace Va.

16 (a) Informant Mrs. Hannah Smead
(b) Address 927 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 2044 Edmonden St.

19 OCT 7 1944 (Date rec'd by registrar) (b) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 4 1944 at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/1 1944 and that I last saw him alive on 9/30 1944.

Immediate cause of death: Cerebral hemorrhage

	Duration
Due to: Paralysis	
Due to:	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 1 My Dear Office Date signed Oct 6 1944

Jos. Williams, M.D. Registrar

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21349 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3802 Southern Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 Southern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LENA GRANZER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Granzer

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1859

8. AGE: Years 85 | Months 1 | Days 22 | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Frederick Thiele
13. Birthplace Hanover, Germany

MOTHER
14. Maiden Name Elizabeth Ochs
15. Birthplace Germany

16 (a) Informant Mrs. John Kaufman
(b) Address 3802 Southern Avenue

17 (a) Burial (b) Date thereof 10-7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sader & Sons, Inc
(b) Address North Ave. & Broadway

19 (a) (b) Huntington Williams M.D.
(Date rec'd by registrar)

VS 1st OCT 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4, 1944 at 10.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944 to Oct 4 1944 and that I last saw ... alive on Oct 4 1944

Immediate cause of death: Senile Myocarditis — Duration 2 Yrs
Due to arteriosclerosis — 2 yrs
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. F. Kaufman M.D.
Address 8-6-39 Date signed Oct 7 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21350 / 61

Registered No. G21350

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312
(c) Hospital or institution: Mercy Hospital, Balto, Md
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 72 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3537 Falls Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Council

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Tom Brown

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/1871

8. AGE: Years 72 | Months 9 | Days 19 | If less than one day hr. min.

9. Birthplace Balto. Co. Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Snowden T. Disney
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Amelia Belt
15. Birthplace Balto. Md.

16 (a) Informant Hospital Records.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-44 (month) (day) (year)
(c) Cemetery or crematory Fernwood.
Location Philadelphia, Pa.

18 (a) Funeral director L. J. Rafferty
(b) Address 5216 Harford Rd.

19 (a) (Date rec'd by Registrar) OCT 7 (b) 1944 Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1944, at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 6 1944, and that I last saw her alive on 10/6 1944.

	Duration
Immediate cause of death: Cardio-respiratory failure & Terminal.	
Due to: Hypertensive Cardio-vascular disease	20 yrs
Due to: & Diabetes	15 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Earl H. Patterson M. D.
Address Mercy Hospital Date signed 10/7/44

Hinton Williams, M.D.

G21351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 c

Registered No. G21351

TH. 86391

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 months
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 322 Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jan Chin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Chinese

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1888

8. AGE: Years 55 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace California
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Lhin Leung (D
13. Birthplace China

MOTHER
14. Maiden Name Mayshea
15. Birthplace China

16 (a) Informant

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.
Location Windsor Mill Rd. Woodlawn

18 (a) Funeral director STEWART & MOWEN COMPANY Inc.
(b) Address (W. F. MOWEN SUC.) 100 W. NORTH AVENUE

19 OCT 7 1944 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION 7.30 P. A.

20. DATE OF DEATH Oct 5, 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 9 1944, to Oct. 5 1944, and that I last saw her (him) alive on Oct 5 1944.

Immediate cause of death: Pulmonary Thrombosis Accident

Duration

Due to Arteriosclerosis

Due to

Other Conditions C.N.S Lues

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Peccopi M. D.
Address Bala. City Hosp Date signed 10-5-44

G21352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G21352

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 119 S. Chester St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 119 S. Chester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jadwiga Zezulinski

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Felix Zezulinski

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace Poland (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business At home

FATHER
12. Name Antoni Skibinski
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Felix Zezulinski
(b) Address 119 S. Chester St.

17 (a) Burrial (Burial, cremation, or removal) (b) Date thereof Oct. 9/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore

18 (a) Funeral director Fred W. Wagaczynski
(b) Address 1930 Eastern Ave.

DOCT 7 1944 (Date rec'd by Local Registrar) for Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 5 1944, at 9¼ M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944, to Oct. 5 1944, and that I last saw him alive on Oct. 5 1944

	Duration
Immediate cause of death: Myocardial Insufficiency	10 days
Due to Chronic Myocarditis	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Szczerbicki M. D.
Address 1802 Eastern Ave. Date signed 10-7-44

C21353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121

Registered No. C21353

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens Ave
(c) Hospital or institution:
St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5412 Frederick ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Ida J. Maloney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife Howard G.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 1887

8. AGE: Years	Months	Days	If less than one day
57	3mo	27	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Frank Vierengle
13. Birthplace Germany

MOTHER
14. Maiden Name Viengel
15. Birthplace

16 (a) Informant Howard G. Maloney
(b) Address 5412 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 7/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director H. H. Withee
(b) Address 4484 Edmondson Ave

OCT 7 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/22 1944 to 10/5/1944 and that I last saw h[illegible] alive on 10/5 1944.

Immediate cause of death: Appendectomy
Due to: stcot peritonitis

Duration
13 days

Due to

Other Conditions: Cardiac Embolism

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Cliff Routh, Jr. M. D.
Address [illegible] Hospital Date signed 10/9/44

G21354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G21354

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2120 Mura St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2120 Mura St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Walter E. Martin

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-05-7738

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ruth Hannel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1884

8. AGE: Years	Months	Days	If less than one day
60	2	23	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Farmer

11. Industry or business Coast Guard Depot

FATHER
12. Name Thomas Martin
13. Birthplace Maryland

MOTHER
14. Maiden Name Ida White Lowe
15. Birthplace Maryland

16 (a) Informant Mrs Ruth Martin
(b) Address 2120 Mura St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3401 Frederick Rd

18 (a) Funeral director Harry H. Wiltse
(b) Address 1610 Edmondson Ave

19 (a) OCT 17 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1944, at 11.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/2 19 44 to 10/4 19 44 and that I last saw h alive on 10/4 19 44

Immediate cause of death Carcinoma of rectum — Duration 1 yr

Due to

Due to

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller MD M. D.

Address 2026 Wilkens Ave Date signed 10/15/44

G21355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21355

10 #30487

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 14 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Annie Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10, 1873

8. AGE: Years 70 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name John Montgomery
13. Birthplace Ireland

MOTHER: 14. Maiden Name Anna Unger
15. Birthplace Baltimore, Md.

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: 3901 Frederick Rd.

18 (a) Funeral director: Henry H. Weitzler
(b) Address: 4101 Edmondson Ave.

19 (a) (Filed by registrar) (b) Huntington Williams M.D.

OCT 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1944 at 8:15a M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 22, 1944 to Oct. 6, 1944, and that I last saw her alive on Oct. 6, 1944.

	Duration
Immediate cause of death: Diabetes Mellitus	?
Due to: Carcinoma of Uterus	?
Due to:	
Other Conditions: Diabetic gangrene of left leg	

(Include pregnancy within 3 months of death)

Date of operation 9-6-44

Major findings of operation: Gangrene of left right leg

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: S. P. Asvara M. D.

Address 4940 Eastern Ave. Date signed 10-6-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

621356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 123

621356 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4200 Dillon Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Dillon Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dolores C. Strant

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 19 - 1930

8. AGE: Years 14 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace Allegheny Co - Md. (Town, county, and state)

10. Usual Occupation At school

11. Industry or business

FATHER
12. Name Adam P. Strant
13. Birthplace Md.

MOTHER
14. Maiden Name May E. Haller
15. Birthplace Md.

16 (a) Informant Mr. Adam P. Strant
(b) Address 4200 Dillon Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-9-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director Leonard J. Rusk
(b) Address 5305 Harford Road

(a) Date rec'd by Registrar OCT 7 1944 (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6th 1944 at 7 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944 to Oct 6 1944 and that I last saw her alive on Oct 6 1944.

Immediate cause of death: Acute Peritonitis — Duration: 1 day
Due to: Acute Diverticulitis — 3 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature George Dawson M.D.
Address 4308 Harford Ave. Date signed 10/5/44

G21357

BALTIMORE CITY HEALTH DEPARTMENT X ✓ G21357

CERTIFICATE OF DEATH 54a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va (b) County
(c) City or town Parsons
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(e) Citizen of foreign country? (If so, give location) No (Yes or No)
If yes, name country

3 (a) FULL NAME Mabel Quvil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7, 1902

8. AGE: Years	Months	Days	If less than one day
42	6	4	0 hr. min.

9. Birthplace Tucker County, West Virginia (Town, county, and state)

10. Usual Occupation Stenographer

11. Industry or business Lantyer's Stenographer

FATHER
12. Name J. L. Quvil
13. Birthplace W. Va

MOTHER
14. Maiden Name Minnie Bishop
15. Birthplace W. Va

16 (a) Informant James L. Quvil
(b) Address 1605 Light Street, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Parsons
Location Parsons, W. Va.

18 (a) Funeral director Fitzpatrick & Cole
(b) Address 1200 Lombard St.

OCT 8 1944 (c) Filing for Williamsport, Md.
Date rec'd by Registrar Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7 1944 at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944 to 10/7 1944 and that I last saw her alive on 10/7 1944.

Immediate cause of death Cerebral Edema

Due to Intra-cranial irritation

Due to Brain Tumor

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/27/44

Major findings of operation: Spongioblastoma Multiforme

of autopsy: Post-mortem Brain Tumor

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. H. Frosberg Jr. M. D.
Address University Hosp., Balto., Md. Date signed 10/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21358 ✓ G21358

459847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Bateman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leslie Kenyne

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Bertha
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) 7-14-05

8. AGE: Years	Months	Days	If less than one day
39	2	23	hr. min.

9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation Advertising.
11. Industry or business

FATHER
12. Name Herman Kenyne
13. Birthplace Russia

MOTHER
14. Maiden Name Flora Lazarus
15. Birthplace N.Y.

16 (a) Informant Relatives.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) removal (b) Date thereof 10-7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Newyork N.Y.

18 (a) Funeral director Jack Lewis Inc
(b) Address 1409 E Balto St

OCT 8 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-7 1944 at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-28 1944 to Oct-7 1944 and that I last saw [redacted] alive on Oct 1944

Immediate cause of death	Duration
Adrenal Hemorrhage	1 30 min.
Due to Metastatic carcinoma primary site unde-	4 mo
Due to Termine	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Generalized Carcinoma Toto

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Laurence Richardson M.D.
Address Johns Hopkins Hosp Date signed Oct 7 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
Spaces that are is especially important. Physicians: please write the causes of death clearly and legibly.

G21359 ✓ G21359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1112 Haverhill Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1112 Haverhill Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perry McCleary

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Elizabeth McCleary
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 22, 1857

8. AGE: Years	Months	Days	If less than one day
87	8	14	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Retired-Laborer
11. Industry or business

FATHER
12. Name Mr. McCleary
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mr. E. Willis Lamoreau
(b) Address 1003 W. Baltimore St.

17 (a) Burial (b) Date thereof Oct. 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral director E. Willis Lamoreau
(b) Address 1003 W. Baltimore St.

OCT 8 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944, to Oct 6 1944, and that I last saw h im alive on Oct 5 1944

Immediate cause of death Cerebral Hemorrhage — Duration 36 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. McCollum M D
M. D.

Address 3321 Frederick Ave Date signed 10-6-44

G21360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓G21360 95c Registered No.

MARRIAGE RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2134 Prestman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2134 Prestman St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Freda Ballan

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Simon J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years	Months	Days	If less than one day
48			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation
11. Industry or business House Work

FATHER
12. Name Israel Schweitzer
13. Birthplace Poland

MOTHER
14. Maiden Name Bertha Handelman
15. Birthplace Poland

16 (a) Informant Simon J. Ballan
(b) Address 2134 Prestman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Young Men Cem
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) Name filed by [illegible] (b) Huntington Williams, M.D. Registrar

OCT 7 1944

VS 180

MEDICAL CERTIFICATION 4.20

20. DATE OF DEATH October 6, 1944 at A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to 10/6/1944 and that I last saw h[illegible] alive on 10/6 1944

Immediate cause of death Coronary Thrombosis — Duration Eleven

Due to Coronary Sclerosis — 4 years

Due to Cardiac Hypertrophy — 10 years

Due to Hypertension

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature THEODORE COOPER M. D.
Address 210 7 Park Ave Date signed 10/9/44

G21361

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21361

CERTIFICATE OF DEATH 94a

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4122 Forest Park Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore ✓
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4122 Farest Park Ave
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Samuel Pumpian

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nellie
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug, 25, 1883

8. AGE: Years	Months	Days	If less than one day
61	1	12	..... hr. ..... min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation .....
11. Industry or business Clothing Manfct.

FATHER
12. Name Joseph Pumpian
13. Birthplace Russia

MOTHER
14. Maiden Name Dora ?
15. Birthplace Russia

16 (a) Informant Jerome Pumpian
(b) Address 4122 Forest Park Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Beth Tfiloh Cemetery
Location Windsor Mill Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) ..... (Date rec'd by registrar) (b) ..... Registrar

OCT 8 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION 8.05

20. DATE OF DEATH October 7, 1944, at P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sep. 1944 to 10-7 1944
and that I last saw h.... alive on Oct. 1944

Immediate cause of death	Duration
Acute Coronary Thrombosis	
Due to Hypertension	
Due to Chronic Sclerosis	years.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ..... M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Bernard J. Cohen M. D.
Address Marlborough Date signed 10/8/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21362 ✓ G21362

AB-89715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
Md.
(a) State (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. The Anchorage-Thames & Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Schroeder

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30-1903

8. AGE: Years 41 | Months 2 | Days 6 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Schroeder
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Luckhardt
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct 10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location Old Frederick Road

18 (a) Funeral director John A. Horan
(b) Address 3000 E. Baltimore St

OCT 7 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-8- 1944, to 10-6 1944 and that I last saw h. 1m alive on 10-6 1944.

Immediate cause of death Bacterial Endocarditis.

Duration 4 wks?

Due to Rheumatic Heart Disease (Chronic)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Phillips M. D.
Address Balt. City Hosp Date signed 10-7-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21363 | BALTIMORE CITY HEALTH DEPARTMENT | G21363

CERTIFICATE OF DEATH 112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5004 Belair Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5004 Belair Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis C. Riesch

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 213-12-8239

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Charlotte Riesch
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) December 15, 1887

8. AGE: Years	Months	Days	If less than one day
62	9	21	hr. min.

9. Birthplace Cincinnati, Ohio
(Town, county, and state)
10. Usual Occupation Artist
11. Industry or business

FATHER
12. Name —
13. Birthplace Germany.

MOTHER
14. Maiden Name Katherine Baely.
15. Birthplace Germany

16 (a) Informant Charlotte Riesch
(b) Address 5004 Belair Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North & Milton Aves.

18 (a) Funeral director Howard N. Blight Jr.
(b) Address 4914 Belair Road.

19 (a) Date received by registrar OCT 8 1944 (b) Registrar
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 24 1944, to Oct 5 1944, and that I last saw h alive on Oct 5 1944

Immediate cause of death	Duration
myocarditis	20 dys
Due to Arteriosclerosis	10 yrs
Due to Renal Causes of	
Asthma	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Edward L. Zimmerman M. D.
Address 9858 Harford Rd Date signed 10/6/44

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21364 ✓ G21364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2603 DENISON ST
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 34 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give location)
(d) Street No. 1441 E. Fayette Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Grossman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Murry Grossman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Rumania
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Harry Grossman
13. Birthplace Rumania

MOTHER
14. Maiden Name Sagar
15. Birthplace Rumania

16 (a) Informant Wm Burkhardt
(b) Address 2603 Denison St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-8-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Memory
Location

18 (a) Funeral director ACP Sayers Inc
(b) Address 1439 E. Balto St
(b) Huntington Williams, M.D. Registrar

OCT 8 1944
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-44 19 .. at 6:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Oct 6 1944 and that I last saw h.. alive on 10/6 1944.

Immediate cause of death: Carcinoma of stomach — Duration: 4 mos

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Sept 20 1944

Major findings of operation: Inoperable gastric Malignancy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Benjamin Miller M. D.

Address 2030 Wilkens Ave Date signed 10/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21365

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

49a

G21365
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Berkley Heights
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 391 Barrington Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura Hochheimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years: 69 | Months | Days | If less than one day: hr. min.

9. Birthplace Phila Pa.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Simon Hochheimer
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestine
15. Birthplace Germany

16 (a) Informant Sy Hochheimer
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-7-44 (month) (day) (year)
(c) Cemetery or crematory Har Sinai
Location Ereman Md

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

OCT 8 1944 (Date rec'd by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6-44 19 , at 1 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to 10/6 1944 and that I last saw h[illegible] alive on 10/6 1944

Immediate cause of death	Duration
Carcinoma of Mandible	
Due to Rectal Carcinomatosis	
Due to Carcinoma Ovary	1 yr.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation May 1944
Major findings of operation: Carcinoma - Rt ovary
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis E. Goodman M. D.
Address 1211 Eutaw Pl Date signed 10/7/44

Huntington Hillsdale, Md

(over) Louis E. Goodman

G21366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21366 Registered No. 61

MARK RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4410 Raspe Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4410 Raspe Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William C Habicht

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Elizabeth H Habicht
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29 1871

8. AGE: Years	Months	Days	If less than one day
73	4	6	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Marine Hardware Mfgr
11. Industry or business

FATHER
12. Name Paul Habicht
13. Birthplace Germany

MOTHER
14. Maiden Name Antonette Jungblutt
15. Birthplace Germany

16 (a) Informant Elizabeth Habicht
(b) Address 4410 Raspe Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Colgate Balto Co Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Orleans St

OCT 7 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1944, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944 to Oct 6 1944 and that I last saw him alive on Oct 6 1944

Immediate cause of death: Chronic myocardial disease — Duration: ?
Due to
Due to
Other Conditions: Diabetes Mellitus, Acute dilatation of heart
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Pen Titchen M. D.
Address 4116 Northern Parkway Date signed 10/7/44

G21367

AB-27644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21367

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6yrs- 11mos- 17days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4411 Marx's Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah McBride

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife John(D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12-1862

8. AGE: Years	Months	Days	If less than one day
82	4	25	hr. min.

9. Birthplace Ireland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Harry Dunrah (D)
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine (D)
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director Williams & Dore
(b) Address 1219 E Fayette St

19 1944 (Date rec'd by registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1944, at 5.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1937, to 10-7 1944, and that I last saw her alive on 10-7 1944.

Immediate cause of death	Duration
Bronchopneumonia	days?
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Hypertensive heart Dis. old hemiplegia	7

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Ante Mort

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature D. M. Pleasants M. D.
Address Balt City Hosp Date signed 10/11/44

G21368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G21368 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 731 Mc Henry St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 731 Mc Henry St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Schwartz

3 (b) If veteran, name war: W
3 (c) Social Security Account No. 1942
4 Sex: F
5. Color or race: Remarked White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: Elmer
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 24 1885
8. AGE: Years 58 57 | Months 9 | Days 16 19 | If less than one day hr. min.
9. Birthplace Emmettsburg Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Hugo Petticord
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Vernon F White
(b) Address 32 S Carrollton Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location
18 (a) Funeral director Fullerton & Son Inc
(b) Address 1214 E Baltimore St
19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1944 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1944 to 10-6 1944 and that I last saw her alive on 10-6 1944

Immediate cause of death: Lobar Pneumonia — Duration: 3 days
Due to: Pyelitis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph Laufantis M. D.
Address 626 Washington Blvd Date signed 10/6/44

VS 150

G21369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G21369 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: University Hosp.
(a) Baltimore City, Maryland
(b) Street address 225 Greene St
(c) Hospital or ~~institution~~

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3305 Abell ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary L. Grosscup

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Widow

6 (b) Name of husband or wife William E
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 2nd 1870

8. AGE: Years	Months	Days	If less than one day
74	4	5	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business at Home

FATHER
12. Name Wm Conway
13. Birthplace Md.

MOTHER
14. Maiden Name Bratzer
15. Birthplace Md.

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 10/10/44
(Burial, cremation or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Mt. Olivet
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 422 E. Fayette St Huntington Williams, M.D.

OCT 8 1944
(Date rec'd by registrar)

(b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1944 at 11:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29 1944 to 10/7 1944 and that I last saw her alive on 9/28 1944

Immediate cause of death General cachexia — Duration

Due to Generalized carcinomatosis

Due to C. A. of rectum

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Goldstein M. D.
Address Univ. Hosp. Date signed 10/13/44

G21370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 61

G21370

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The spelling of names is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Wilkens & Caton Ave.

(c) Hospital or institution: St. Agnes Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Balto Co 28 (If outside city or town limits, write COUNTY and give town)

(d) Street No. Rolling Rd. Catons. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Mrs. Alverta Deitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	widowed

6 (b) Name of husband or wife Peter Deitz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4th 1873

8. AGE: Years	Months	Days	If less than one day
71	9	3	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER

12. Name Louis A. Reinhardt

13. Birthplace Md

MOTHER

14. Maiden Name Mollie Uhlmann

15. Birthplace Md.

16 (a) Informant Mrs Thomas F. Maher

(b) Address Catonsville Md.

17 (a) Method of disposal (Burial, cremation, removal)

(b) Date thereof 10/10/44 (month) (day) (year)

(c) Cemetery or crematory London Park

Location Balto. Md

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

OCT 9 1944 (Date received by registrar) (b) Huntington for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7-44 19 , at 11:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1944 to 10-7 1944 and that I last saw her alive on 10-7 1944.

Immediate cause of death Respiratory failure

Due to Chronic Myocarditis

Due to Senile Psychosis

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature William J. Bryson M.D.

Address St. Agnes Hospital Date signed 10/12/44

G21371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1220

MARGIN RESERVED FOR BINDING

CREASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4728 YORK RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4728 York Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY GARDNER HOUSEL

3 (b) If veteran, name war: NONE
3 (c) Social Security Account No. 198-24-8494

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: MARY JANE
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAY 24 1863

8. AGE: Years 81 | Months 4 | Days 6 | If less than one day: hr. min.

9. Birthplace LOCK HAVEN, PA. (Town, county, and state)

10. Usual Occupation SALESMAN

11. Industry or business STERN + CO. RETIRED

FATHER
12. Name CHARLES R. HOUSEL
13. Birthplace PA.

MOTHER
14. Maiden Name REBECCA GARDNER
15. Birthplace PA.

16 (a) Informant Maxwell G. Housel
Eldgwyth Manor Apts. Ilfield Dr. Roby Rd.

17 (a) Removal (b) Date thereof 10/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Clifton Heights
Location Delaware Co. Pa.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 10-8-44 (b) Emerson Williams M.D.
(Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 7 1944 at 4 25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944, to Oct 7 1944, and that I last saw h.[illegible] alive on Oct 7 1944

Immediate cause of death	Duration
Acute pulmonary edema	8 hrs.
Due to Strangulated umbilical hernia	24 hrs.
Due to Acute glomerular nephritis	3 days
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Anthony J Thomas
Address 4600 York Rd Date signed 10/12/44 M. D.

VS 150

G21372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G21372
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Guilford + 33rd
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1324 Eutaw Place.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Sheridan Hamill

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex M

5. Color or race white

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 12, 1861

8. AGE: Years 82 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and State)

10. Usual Occupation Retired
11. Industry or business Dealer in Real Estate.

FATHER
12. Name Peter Hamill
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Martin
15. Birthplace Ireland

16 (a) Informant Mrs Mary Rathern
(b) Address 5a Hopkins Apts St Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9. 44
(month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location 3804 Frederick Ave

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 6 1944 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1944 to Oct 6 1944, and that I last saw him alive on Oct 6 1944

Immediate cause of death Cardiorespiratory failure. — Duration

Due to Intestinal obstruction — Duration

Due to Carcinoma of Colon — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J Van Dell III M. D.
Address Union Memorial Hosp Date signed 10-6-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21373 G21373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. 13

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 W. NORTH AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) no
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 W. NORTH AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM D. SMITH

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife JEMIMA M.J.H.SMITH
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) JUNE 10 1889

8. AGE: Years	Months	Days	If less than one day
55	3	27	hr. min.

9. Birthplace SCOTLAND
(Town, county, and state)
10. Usual Occupation ELECTRICIAN & PAINTER
11. Industry or business

FATHER
12. Name WM. D. SMITH
13. Birthplace SCOTLAND

MOTHER
14. Maiden Name ELIZABETH DRYSDALE
15. Birthplace SCOTLAND

16 (a) Informant MRS. JEMIMA M.J.H.SMITH
(b) Address 930 W. NORTH AVE.

17 (a) BURIAL (b) Date thereof OCT 10.1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory DRUID RIDGE CEMETERY
Location PIKESVILLE, BALTO. CO., MD.

18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 EUTAW PLACE

OCT 8 1944 Registrar for William H. Hall
(Date filed by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 6.1944 19 6:15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/1 19 44 to 10/6 19 44, and that I last saw [illegible] alive on 10/5 19 44

Immediate cause of death: Acute Coronary Disease — Duration: Instant

Due to:

Due to:

Other Acute Brain Abscess — 7 days

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [signature]
Address 1901 EUTAW PLACE Date signed 10/7/44

G21374 BALTIMORE CITY HEALTH DEPARTMENT G21374

CERTIFICATE OF DEATH 1927

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 115 N Cary st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) Same and (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 115 N Cary St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles F Preiss

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Carrie Preiss
6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) Dec 16 - 1867

8. AGE: Years	Months	Days	If less than one day
76	9	27	hr. min.

9. Birthplace New York -
(Town, county, and state)
10. Usual Occupation
11. Industry or business Retired

FATHER
12. Name John Preiss
13. Birthplace New York -

MOTHER
14. Maiden Name Clementine Winkler
15. Birthplace New York -

16 (a) Informant Carrie Preiss
(b) Address 115 N Cary St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Eastern Ave Baltimore, Md

19 (a) 1944 (Date filed by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6th 1944 at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 2, 1943, to Oct. 6, 1944, and that I last saw him alive on Oct. 6, 1944.

Immediate cause of death: Chronic Myocarditis — Duration: 2 years
Due to —
Due to —
Other Conditions None
(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Frank H. Ogburn M. D.
Address 2701 N. Calvert Date signed Oct. 7, 44

VS 250

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

G21375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21375 Registered No. 48 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 846 N. Eutaw St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 846 N. Eutaw St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ruby Elizabeth Blair

3 (b) If veteran, name war

3 (c) Social Security Account No. 211-09-9145

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife Charles Blair
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Sept 7 1905

8. AGE: Years	Months	Days	If less than one day: hr.	min.
39	—	8		

9. Birthplace Bristol, Va. (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Rutledge

FATHER
12. Name Thomas H. Houser
13. Birthplace Tenn.

MOTHER
14. Maiden Name Carrie Hall
15. Birthplace Va

16 (a) Informant Mrs Charles Blair
(b) Address 846 N. Eutaw St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)
(c) Cemetery or crematory Lutsong
Location Bristol, Va

18 (a) Funeral director Fredericks & Co
(b) Address Frost Lombard

19 (a) (State registrar) (b) Huntington Williams MD

OCT 8 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6/44 19 , at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944 to 10/6 1944 and that I last saw h alive on 10/6 1944

Immediate cause of death Carcinoma of Cervix with generalized metastasis

Due to —

Due to —

Other Conditions none

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy:

Duration: 2

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
Means of injury

Signature Harry Beitel

Address 226 Hunter St Date signed 10/8/44

G21376

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21376

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 Cold Spring Lane
(c) Hospital or institution: Cold Spring House
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 Mo.
(e) Length of stay in Baltimore (yrs., mos., or days) Abt 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Cold Spring Lane
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward W. Hooper

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	widowed

6 (b) Name of husband or wife Mary Cox Hooper
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27, 1878

8. AGE: Years	Months	Days	If less than one day
66	0	10	hr. min.

9. Birthplace Taylorsville, Carroll Co. Md.
(Town, county, and state)
10. Usual Occupation day laborer
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Catherine Hooper
15. Birthplace Carroll Co. Md.

16 (a) Informant Thomas Hooper
(b) Address E. Main St. Westminster Md

17 (a) Burial (b) Date thereof 10 10 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Warfieldsburg Cem.
Location Rural, Rg. Westminster Md.

18 (a) Funeral director Jos. E. Myers, Jr.
(b) Address Westminster, Md.

19 (a) 1944 (b) Huntington Willis
(Date) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 1944; at 9.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6th 1944 to Oct 7th 1944 and that I last saw h[illegible] alive on Oct 7th 1944

Immediate cause of death (a) Pneumonia. Duration 72 hrs
Due to (b) Cystic of Ovarian Type Duration 2 yrs.
Due to (c) Hypertension. Duration 7
Due to (d) Arteriosclerosis Duration
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. A. Lueck M. D.
Address 411 Face Rd Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21377 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3108 Northern Pkwy.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Northern Parkway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Teresa Gossman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Casper I. Gossman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 23, 1862

8. AGE: Years	Months	Days	If less than one day
82	6	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Henry H. Kaufman
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Heine
15. Birthplace Maryland

16 (a) Informant Mrs. James M. Knight
(b) Address 3108 Northern Pkwy. #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

(a) Date received (Registrar) (b) Registrar

OCT 8 1944

VS 116

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/7/1944 to 10/7/1944, and that I last saw h[illegible] alive on 10/2/1944

Immediate cause of death Cerebral hemorrhage — Duration 3 mos 2 days

Due to Arteriosclerosis — Duration 7

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 10/8/44 Date signed 10/8/44

3195 G21378

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 556

G21378 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County.....
(c) City or town St. Paul (If outside city or town limits, write RURAL and give town)
(d) Street No. St Paul ? (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Mary FEATHERSTON

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Richard L. Featherston

6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): 7-24-03

8. AGE: Years: 41 | Months: 2 | Days: 14 | If less than one day: ....hr. ....min.

9. Birthplace: Va. (Town, county, and state)

10. Usual Occupation: teacher

11. Industry or business

FATHER — 12. Name: John M. Hillman
13. Birthplace: Va.

MOTHER — 14. Maiden Name: Ella Broadwater
15. Birthplace: Va.

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 8 1944 (month) (day) (year)
(c) Cemetery or crematory: Abingdon Va
Location: Abingdon Va

18 (a) Funeral director: Latta & Dunford Funeral Home
(b) Address: 2901 Bel Air Rd

19 (a) (Date received by Registrar) (b) Registrar

OCT 10 1944 VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1944 at 12 00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1944 to Oct 8 1944 and that I last saw her alive on 1944

	Duration
Immediate cause of death: Cardiac & Respiratory Failure	20 hrs
Due to: General Cachexia	4 wks
Due to: Lymphocytic Lymphoblastoma	?4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury.....

23. Signature: Laurie Pickard M.D.
Address: Johns Hopkins Hospital Date signed: 10/9/44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

AG 30379

BALTIMORE CITY HEALTH DEPARTMENT X 55a

CERTIFICATE OF DEATH

Registered No. G21379

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State DC (b) County.....
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 5300 Fairmount Rd. S.E. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Herbert J. Coulson
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-43

8. AGE: Years	Months	Days	If less than one day
1	4	27	hr. min.

9. Birthplace Penn (town, county, and state)
10. Usual Occupation Child
11. Industry or business

FATHER 12. Name Herbert Coulson
13. Birthplace Va

MOTHER 14. Maiden Name Margaret Breightner
15. Birthplace Pa

16 (a) Informant Record
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 9 1944 (month) (day) (year)
(c) Cemetery or crematory Ft Marys
Location Mt Thrysloume Pa.
18 (a) Funeral director W. A. Fenner
(b) Address Amoxy Pa. (Huntingdon Williamsburg Mt)

OCT 9 1944 (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944 at 7 1/2 M
21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1944 to Oct 7 1944 and that I last saw he alive on Oct 7 1944
Immediate cause of death Neuroblastoma of Left Adrenal & Metastasis — Duration 5 weeks
Due to.....
Due to.....
Other Conditions.....
(Include pregnancy within 3 months of death)
Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence.....at.....M
(c) Where did injury occur?.....(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?.....While at work?.....(Specify type of place)
(e) Means of injury.....
23. Signature Alan C. Woods Jr. M.D.
Address Johns Hopkins Hospital Date signed 10/7/44

G21380
M - 84841

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21380
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 - 25
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2311 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernice Cyphert

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 13, 1917

8. AGE: Years	Months	Days	If less than one day
27	7	24	hr. min.

9. Birthplace Pa.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Burton Gates
13. Birthplace Pa.

MOTHER
14. Maiden Name Catherine Gallagher
15. Birthplace Pa.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Clarion Pa.

18 (a) Funeral director A. Ruley Slack
(b) Address 4907 York Road
(Date received) (Registrar) Huntington Williams, M.D.

OCT 9 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944, at 2:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Oct 7 1944, and that I last saw h[illegible] alive on Oct 7 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Pulmonary tuberculosis	
Due to	
Other Conditions Laryngeal tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 9/7/44

VS 150

G21381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

AB-87006

13B

Registered No. G21381

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the cause of death clearly and legibly. Underline the correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days): 6- &-19days

(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Maryland (b) County: Baltimore

(c) City or town: Lansdowne (If outside city or town limits, write RURAL and give town)

(d) Street No.: # 905. No. Henry St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME: Mary Ann Poper or Purper

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.-1-1887

8. AGE: Years	Months	Days	If less than one day
57	8	5	hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation: house work

11. Industry or business: at home

FATHER:
12. Name: George Williams
13. Birthplace: Baltimore, Md.

MOTHER:
14. Maiden Name: Henriette Marlos
15. Birthplace: Maryland

16 (a) Informant: Baltimore City Hospitals (Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/44 (month) (day) (year)

(c) Cemetery or crematory: Lowenstein Cem.
Location: 6115 O'Donnell Street

18 (a) Funeral director: John J. Cowan & Son
(b) Address: 90-03 Collins Ave.

19 OCT 9 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-6 1944, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17 1944, to 10-6 1944, and that I last saw her alive on 10-6 1944.

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence: at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Harold Dillon

Address: Balto City Hosp Date signed: 10/7/44

G21382

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1108

G21382 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 N. Washington St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 N. WASHINGTON ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA M MEISEL

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM.	WHITE	WIDOW

6 (b) Name of husband or wife THOMAS G. MEISEL
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MARCH 4 1864

8. AGE: Years	Months	Days	If less than one day
80	7	3	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WORK
11. Industry or business AT HOME

FATHER
12. Name NOT KNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name NOT KNOWN
15. Birthplace GERMANY.

16 (a) Informant JOSEPH. MEISEL
(b) Address 900 ST. CHARLES AVE ARBUTUS

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 10-44 (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BALTIMORE MD

18 (a) Funeral director Bernard C Hasle
(b) Address 121 E Hoyt St. Huntingtown Williams, MD

19 DEC 9 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 7 1944 at 6:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 7 1944 and that I last saw h alive on Oct 7 1944

	Duration
Immediate cause of death Lobar Pneumonia	4 days
Due to Pulmonary Infarct	1 days
Due to Aortic Sclerosis Hypertension & Syph. Chronic Valvular Disease	3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph Meisel M. D.
Address 1101 E Fayette St Date signed Oct 7/44

VS 150

G21383

AB-80964

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G21383
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2914 Parkwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Baby Boy Dryden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept- 26-1944

8. AGE: Years | Months | Days: 1 | If less than one day: 36 hr. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Stanley Dryden
13. Birthplace

MOTHER
14. Maiden Name Beulah Holston
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) Cremated (9AM) (b) Date thereof 10-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. City Hosp. Crem.
Location 4940 Eastern Avenue

18 (a) Funeral director
(b)

19 OCT 6 1944
(Date rec'd by registrar) Huntington Williams, MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept- 27 1944, at 6.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1944 to 9-27 1944, and that I last saw him alive on 9-27- 1944.

Immediate cause of death	Duration
prematurity	1 day
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis W. Halfield M. D.
Address B C H Date signed 9-27-44

VS 150

G21384

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G21384

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3909 Dorchester Rd.
(c) Hospital or institution:
1510
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3909 Dorchester Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Wallace Holness

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	070-07-9996

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	Married

6 (b) Name of husband or wife Florence May
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1883

8. AGE: Years	Months	Days	If less than one day
61	0	24	hr. min.

9. Birthplace Montreal Canada
(Town, county, and state)
10. Usual Occupation Engineer for
11. Industry or business Balmar Corp.

FATHER
12. Name Tracey Holness
13. Birthplace England

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. Florence Holness
(b) Address 3909 Dorchester Rd.

17 (a) Removal (b) Date thereof 10/9/44
(Burial, cremation, or removal) (mouth) (day) (year)
(c) Cemetery or crematory Forest Lawn Cemetery
Location Buffalo N.Y.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves.

19 (a) OCT 9 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944, at 7.00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944, to Oct 7 1944, and that I last saw h/xx alive on Oct 7 1944.

Immediate cause of death Carcinoma of descending colon with generalized metastasis — Duration 1 yr.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Nov 24, 1943, Jan 13, 1944
Major findings of operation: Carcinoma of descending colon
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William E. Gilmore M. D.
Address 108 E. 33rd St. Baltimore, Md. Date signed 10-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21385

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1100 W Caroline ave
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 N. Calvert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Schmidt — Pauline Schmidt

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3rd 1875

8. AGE: Years	Months	Days	If less than one day
69	1	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Emil Stockhausen
13. Birthplace Germany

MOTHER
14. Maiden Name Anna Pfeil
15. Birthplace Germany

16 (a) Informant Mr. William Stockhausen
(b) Address 3402 Oakenshaw Place

17 (a) Burial (b) Date thereof 10/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director William J. Tickner & Sons
(b) Address North & Pennsylvania Aves

OCT 9 1944 (b) Huntington Williams, M.D.
Date rec'd by Local Registrar — Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1944, at 12 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5 1944, to 10/8 1944, and that I last saw h[er] alive on 10/8 1944.

Immediate cause of death: Respiratory failure
Cardiac failure
Due to Coronary occlusion
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Duration

Date of operation
Major findings of operation: Diseased Heart
of autopsy: Pulmonary & Cardiac Infarction

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Archie L. Simonds M.D.
Address 14 E. Lafayette Ave Date signed 10/8/44

G21386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G21386

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 St Mathew St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5

(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town [redacted] Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 St. Mathew St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stoner Lee.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband Hardie Lee

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 11-20-1902

8. AGE: Years 41 | Months 10 | Days 24 | If less than one day hr. min. 5

9. Birthplace Clayton N. C.
(Town, county, state or foreign country)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Sidney Heath
13. Birthplace North Carolina

MOTHER
14. Maiden Name Mollie Lee
15. Birthplace North Carolina

16 (a) Informant Hardie Lee
(b) Address 1200 St. Mathew St

17 (a) (Burial, cremation, or removal) (b) Date thereof 10-9-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. St. Caught.

18 (a) Funeral director Lottie Gross
(b) Address 1408 Ashland Ave.

19 (a) (Date rec'd by reg.) OCT 9 1944 (b) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-44 19 at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 5, 19 44 to Oct 5, 19 44, and that I last saw h[illegible] alive on Oct 2, 19 44.

Immediate cause of death
Hypertension Cardiac Renal Failure
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Duration
2 yrs

Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin Adam, M. D.
Address 312 E 23rd St Date signed 10-7-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2856 88

BALTIMORE CITY HEALTH DEPARTMENT

G21387 CERTIFICATE OF DEATH 1579 Registered No. G21387

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 May Court (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Betty a. Lee

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. child

6 (b) Name of husband or wife | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-9-43

8. AGE: Years 1 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Lee
13. Birthplace ?

MOTHER 14. Maiden Name Guinevere Worthem
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/8/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 7000 Brantley Ave

19 (a) Filed by registrar OCT 9 1944 Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5- 1944 at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25- 1944 to 10-5- 1944, and that I last saw her alive on 10-5- 1944.

Immediate cause of death Respiratory failure during general anesthesia

Due to

Due to

Other Conditions Cleft palate

(Include pregnancy within 3 months of death)

Date of operation 10/5/44

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Saunders M.D.
Address Johns Hopkins Hospital Signed 10/8/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G21388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G21388

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1444 n. Parrish st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimor (If outside city or town limits, write RURAL and give town)
(d) Street No. 1444 n. Parrish st (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Gail Crosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fem.	Col.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-89

8. AGE: Years	Months	Days	If less than one day
65	1	1	hr. min.

9. Birthplace Baltimor, Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

MOTHER / FATHER

12. Name Mose Crosby
13. Birthplace Md.
14. Maiden Name Harriett Gail
15. Birthplace Md

16 (a) Informant Carrie Johnson
(b) Address 638 Woodyear st

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 10, 44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn.
Location md

16 (a) Funeral director George H. Kelson
(b) Address 1303 Pressstman st

19 OCT 9 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-6- 1944, at 9:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 11, 1943 to Oct 6, 1944 and that I last saw h— alive on 10-6- 1944

Immediate cause of death Chronic Valvular heart disease — Duration 15 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George C. Page
Address 1516 n. Mount St. (17) Date signed 10-7-44 M. D.

MARG— RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21389

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH

124 B

Registered No. G21389

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Aug.23,1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since Aug. 23,1944

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town New York City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 453 E. 78th Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER SHERLOCK

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 15, 1901

8. AGE: Years 43 | Months 2 | Days 32 | If less than one day hr. min.

9. Birthplace New York City
(Town, county, and state)

10. Usual Occupation 2nd Mate

11. Industry or business Merchant Marine

FATHER
12. Name Peter Sherlock
13. Birthplace Germany

MOTHER
14. Maiden Name Mary ?
15. Birthplace Germany

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.10.44 (month) (day) (year)
(c) Cemetery or crematory St. Marys (Hampden)
Location Walnut Lane

18 (a) Funeral director Lee Oder
(b) Address 4644 York Rd.

Dated (b) Huntington Williams, M.D. Registrar
OCT 9 1944 (Month) (Day) (Year)

VS 150

MEDICAL CERTIFICATION P.

20. DATE OF DEATH October 6, 1944 at 3:07 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 23, 1944 to Oct. 6, 1944, and that I last saw him alive on Oct. 6, 1944.

Immediate cause of death: Cirrhosis of liver — Duration: Unk.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation Sept. 22, 1944-Laporatomy

Major findings of operation: Cirrhosis liver with esophogeal varices.

of autopsy: As above

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M.D.
Address Baltimore, Md. Date signed 10/6/44

MS-55055

G21390

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21390 Registered No. 130

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5800 Clarks Hill
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5800 Clarks Hill
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Donna Lee Morningstar

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 9-1942

8. AGE: Years 1 | Months 9 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore Maryland
(Town) county, and state

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name John L. Morningstar
13. Birthplace Maryland

MOTHER
14. Maiden Name Doris M. Farman
15. Birthplace Maryland

16 (a) Informant John L Morningstar
(b) Address 5800 Clarks Hill

17 (a) Burial (b) Date thereof Oct. 10. 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgie Funeral Home
(b) Address 3231 Falls Road

19 (a) Oct 9 1944 (b) Huntington Williams, Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7- 1944 at 1:15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1942 to Oct 7 1944 and that I last saw h[er] alive on Oct 6 1944

Immediate cause of death	Duration
Acute dilatation of Heart	1 Hours
Due to Acute nephritis	1 yr -
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hubert M. Foster M.D.
Address 2524 ST. Paul St. Date signed Oct 7-44

G21391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21391

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 915 N. Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 N. Arlington Av. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George R. Sands

3 (b) If veteran, name war

3 (c) Social Security Account No. 708-05-3916

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Ruth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 3, 1914

8. AGE: Years 30 | Months —3 | Days —2 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name George A. Sands
13. Birthplace Howard Co. Md.

MOTHER 14. Maiden Name Mary Barker
15. Birthplace Howard Co. Md.

16 (a) Informant Mary Sands
(b) Address 915 N. Arlington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Dusk Park
Location Howard County Md.

18 (a) Funeral director Mrs. Lee A. Holland
(b) Address 1631 Druid Hill Ave.

OCT 9 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5-44 19 4 , at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 4 1944 to 10-5 19 44, and that I last saw him alive on Oct 4 1944.

Immediate cause of death Pulmonary Hemorrhage Ent Cancer Dilatation — Duration

Due to

Due to Pulmonary T.B.

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

25. Signature [illegible] M.D.
Address 1135 Eutaw Date signed 10/9/44

G21392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21392
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 439 S. Parrish St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John L. Chalk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Julia Chalk

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11, 1884

8. AGE: Years 60 | Months 2 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Stationery Engineer

11. Industry or business Eastern Overall Co

FATHER
12. Name Charles S. Chalk
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary J. Hill
15. Birthplace Washington, D.C.

16 (a) Informant Wm. L. Chalk
(b) Address Millersville, Anne Arundel Co. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 10/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Hampden

18 (a) Funeral director Schenouth & Damm
(b) Address 3615-17 Liberty Heights Ave.

19 (a) OCT 9 1944 (Date rec'd by registrar) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1944, at 2:47 M

21. I certify that I took charge of the remains described above, held an Autopsy/Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury

23. Signature Hunter J. Fridrich M.D. Medical Examiner.
Date signed 10/8/44

VS 161

G21393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21393 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1321 E. Biddle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Selina Wilson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Black

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: James H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER: 12. Name Alexander Stewart
13. Birthplace Md

MOTHER: 14. Maiden Name Janie Raoul
15. Birthplace Md

16 (a) Informant James H. Wilson
(b) Address 1321 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/9/44 (month) (day) (year)

(c) Cemetery or crematory
Location Grasonville, Md

18 (a) Funeral director Joseph B. Lucks & Co.
(b) Address 1314 N. Central Ave

19 (a) OCT 9 1944 (Date received by registrar) Huntington Williams, Md. Address

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 6, 1944, at 1:05 A.M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/5/1944 to 10/6/1944, and that I last saw her alive on October 6 1944.

Immediate cause of death: Cerebral hemorrhage — Duration

Due to: Hypertension, arterial

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Palmer M. D.
Address Maryland Hosp. Date signed 10/6/44

G21394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

/108

G21394
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address East 33rd St.
(c) Hospital or institution: The Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 79yrs, 8mos5d

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3427 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr William Stange

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs William Stange
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 2, 1865

8. AGE: Years	Months	Days	If less than one day
79	8	5	hr. min.

9. Birthplace Baltimore City Maryland
(Town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER
12. Name Mr William Stange
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Mr William H. Stange, son
(b) Address 722 Brookwood Rd Balto.

17 (a) Burial (b) Date thereof Oct 10-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Matthews Cem
Location Baltimore Md

18 (a) Funeral director Mamie Cook Snyder
(b) Address 1600 W. North Ave

19 (a) OCT 9 1944 (b) Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1944, at 3:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from September 30 1944 to October 7 1944, and that I last saw h. i m. alive on October 7, 1944

Immediate cause of death	Duration
Cardio respiratory failure	1 day
Due to Coronary Thrombosis	8 days
Due to	
Other Conditions Lobar Pneumonia	8 days

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. VanLill III M. D.
Address Union Memorial Hosp Date signed 10-7-44

G21395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21395 Registered No. 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Chapel St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GAETANO SAVOCA

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Francis —
13. Birthplace Italy

MOTHER
14. Maiden Name Marie —
15. Birthplace Italy

16 (a) Informant Nancy Fulco
(b) Address 1611 N. Chapel St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Virgilio F.H. Inc.
(b) Address 1546 N. Gay St.

19 (a) OCT 9 1944 (b) Registrar
(Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7, 1944, at 6 25 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to ____ death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Pneumonia Lobar.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. T. Wallenmeyer M.D.
Asst Medical Examiner.
Date signed 10-8-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21396

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21396 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 N Pulaski Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 N. Pulaski Street (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Emma L. Barney

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: John E. Barney
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1870

8. AGE: Years 73 | Months 9 | Days 13 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Arnold
13. Birthplace Germany

MOTHER
14. Maiden Name Ernestina Heil
15. Birthplace Germany

16 (a) Informant Marian L. Barney
(b) Address 519 N. Pulaski Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto. County, Md.

18 (a) Funeral director Geo. D. Schwab
(b) Address 2101 Frederick Avenue

19 OCT 9 1944 (Date rec'd by registrar) Hunter Register for Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1944, at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from April 24 1942 to Oct 8 1944 and that I last saw her alive on Oct. 8 1944.

Immediate cause of death	Duration (a)
Myocardial degeneration -	
Due to Arteriosclerosis -	(c)
Due to Hydrocephalus. Edema	(d)
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel E. Bogorad M. D.
Address 1925 W. Baltimore St. Date signed 10/9/44

VS 3

G21397

G21397
28-89603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 97

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 & 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 Market Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Breen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Marie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15- 1857

8. AGE: Years	Months	Days	If less than one day
87	3	23	hr. min.

9. Birthplace New York
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bryan Breen
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Doyle
15. Birthplace Ireland

16 (a) Informant Baltimore City Hospitals(Records
(b) Address 4940 Eastern Ave.

17 (a) Burial, cremation, or removal (b) Date thereof 10-11-44 (month) (day) (year)
(a) Cemetery or crematory Cleveland
(b) Location Cleveland, Ohio

18 (a) Funeral director F. Rauh & Sons
(b) Address Cleveland, Ohio

OCT 9 1944 (a) Huntington Williams M.D.
(Date rec'd by Registrar) (b)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8 1944 at 11 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 8- 31- 1944 to 10- 8- 1944, and that I last saw h alive on 10- 8- 1944.

	Duration
Immediate cause of death Terminal	
Branch-pneumonia	4 days.
Due to Generalized arteriosclerosis.	?
Due to Emaciation.	5 mos.
Other Conditions Exhaustion	5 mos

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Kenneth Lynch M. D.
Address Balt. City Hosp. Date signed 10/7/44

G21398

BALTIMORE CITY HEALTH DEPARTMENT X G21398

CERTIFICATE OF DEATH 1222 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PEARL PEUGH

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1944

8. AGE: Years	Months	Days	If less than one day
	7	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Stanley Peugh
13. Birthplace Woodbine, Md.

MOTHER
14. Maiden Name Clista Williams
15. Birthplace Rockville, Md.

16 (a) Informant Stanley Peugh
(b) Address Montgomery Rd, Howard Co.

17 (a) Burial (b) Date thereof Oct. 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Good Shepherd
Location Howard Co. Md.

18 (a) Funeral director Easton Sons
(b) Address 608 Frederick Ave. Catonsville

19 (a) OCT 9 1944 (b) Huntzinger for Nathan Coughlin
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7th 19 44, at 11 10 AM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Intussusception

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature H. L. Wallenmeyer M.D.
Medical Examiner
Date signed 10-9-44

G21399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 127a

G21399 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oliver & Eden Streets Street
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 811 S. Conkling Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth W. Booth.

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. NONE

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Clarence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/ 8/85

8. AGE: Years 59 | Months 2 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation House wife

11. Industry or business home

FATHER
12. Name Henry Grieb
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mollie Ogle
15. Birthplace Balto. Md

16 (a) Informant John W. Booth, (son)
(b) Address 3508 Elemly Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Ext.

18 (a) Funeral director Lilly & Zeile Sons
(b) Address 403 S. Wolfe Street

19 OCT 9 1944 (Date rec'd by Reg.) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1944 at 8 27 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1944 to 10/8 1944 and that I last saw her alive on 10/8 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Pulmonary Edema Hypostatic Pneumonia.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/7/44

Major findings of operation: Chronic Cholecystitis - Acute Cholecystitis

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isadore J. Lamonski M. D.

Address 1st Joseph Hospital Date signed 10/8/44

G21400

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

Registered No. G21400

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Write correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive and 31st Street
(c) Hospital or institution:
U. S. Marine Hospital, Baltimore, Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hours
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
New York
(a) State ~~Maryland~~ (b) County
(c) City or town New York
(If outside city or town limits, write RURAL and give town)
(d) Street No. 433 W. 124th St.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME PRIMO GONZALES

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Filipino	Married

6 (b) Name of husband or wife Agripina (Cardena) Gonzalez
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/9/02

8. AGE: Years	Months	Days	If less than one day
42	3	6	hr. min.

9. Birthplace Phillipine Islands
(Town, county, and state)
10. Usual Occupation Galleyman
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Records-US Marine Hospital
(b) Address Baltimore, Maryland

17 (a) Burial (b) Date thereof Oct. 9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location German Hill Road

18 (a) Funeral director Lilly and Zeiler Inc.
(b) Address 403 S. Wolfe St.

19 OCT 9 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 5, 1944, at 11:51 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5, 1944, to Oct. 5, 44, and that I last saw him alive on Oct. 5, 1944.

Immediate cause of death Rheumatic heart disease — Duration Unk.
with Auricular fibrillation
Due to and congestive failure — 2 wks.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Adams
Address US Marine Hospital Date signed 10/9/44

Baltimore, Md.

G21401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G21401 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1203 Hanover St -
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 -
(e) Length of stay in Baltimore (yrs., mos., or days) life -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1203 Hanover St. (If rural give location)
(e) Citizen of foreign country? - (Yes or No) If yes, name country -

3 (a) FULL NAME Elizabeth Schumacher

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Louis

6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1870

8. AGE: Years 73 | Months 11 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name Alfred Frank
13. Birthplace Germany

MOTHER 14. Maiden Name Helen [illegible]
15. Birthplace Germany

16 (a) Informant Miss Elizabeth Schumacher
(b) Address 1203 Hanover St (Daughter)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10-1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill Cem.
Location B. & C. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) OCT 9 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944, at 10 00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1944, to Oct 7 1944 and that I last saw her alive on Oct 6 1944

Immediate cause of death Myocardial Insufficiency

Due to -

Due to -

Other Conditions Diabetes Mellitus
Hypertension
(Include pregnancy within 3 months of death)

Date of operation -

Major findings of operation: -

of autopsy: -

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at - M
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? - While at work? - (Specify type of place)
(e) Means of injury -

23. Signature John A. Schenuit M.D.
Address 1337 S. Charles St. Date signed 10/7/44

G21402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

G21402 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 113 - Barnett
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 113 Barnett
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME James G. Hronk

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mattie A. (nee Saunders)

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Apr. 18, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	19	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation At Home —

11. Industry or business

FATHER — 12. Name John G. Hronk
13. Birthplace Md.

MOTHER — 14. Maiden Name Amanda V. Morgan
15. Birthplace Md.

16 (a) Informant Mrs. Nellie J. Wrape
(b) Address 113 Barnett St. Balto 30

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Aa Co Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 Lanvale St.

19 (a) — (Date rec'd by registrar) (b) Hunter Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7- 1944 at 10:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7/1944 to 10/7/1944 and that I last saw h. im alive on 10/7/1944.

Immediate cause of death Coronary thrombosis — Duration 2 - 3 hours.

Due to —

Due to —

Other Conditions Hypertensive cardio vascular disease
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Harry Deitel M.D.

Address 1226 Hanover St. Date signed 10/8/44

Supplemented: H. L. Wellman Weber M.D. for Robert Lee Graham M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21403 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2318 W. Fayette St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2318 W. Fayette St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Theresa Keith

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife late Joseph Keith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 11th 1860

8. AGE: Years 83 | Months 10 | Days 26 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation House work.

11. Industry or business at home

FATHER 12. Name Geo Effinger

13. Birthplace Germany

MOTHER 14. Maiden Name Waltemore.

15. Birthplace Germany

16 (a) Informant Mrs Mary Lundquist

(b) Address 2318 W. Fayette St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location 4430 Edgar Road

18 (a) Funeral director John Conway & Son

(b) Address 901-03 Hollins St

19 (a) (Date received by registrar) (b) 1944 Registered No.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7, 1944 at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 7 1944 and that I last saw h[illegible] alive on Oct 6 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. A. Carlson M. D.
Address 2145 W Balto Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr James Brown Med Arts Bldg (24 6500)

G21404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21404

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1502 Windermere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1502 Windermere Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Laura D. Carroll

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Widowed

6 (b) Name of husband ~~or wife~~: James R. Carroll

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7th 1872

8. AGE: Years	Months	Days	If less than one day
72	0	1	hr. min.

9. Birthplace Beulah, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William H. Camper
13. Birthplace Md.

MOTHER
14. Maiden Name Lovey Ann Carroll
15. Birthplace Md.

16 (a) Informant W. Gordon Carroll
(b) Address 4606 Harvard Rd College Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44
(month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 OCT 9 1944 (Date rec'd by registrar) (b) Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8th 1944 at 4 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-6 1944, to 10-8 1944, and that I last saw h[illegible] alive on 10-8 1944.

Immediate cause of death Chronic Nephritis Uremia
Due to Chronic Hypertension -
Due to Chronic Myocarditis

Duration
10 years.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James Brown M. D.
Address 10 S Medical Arts Bldg Date signed 10/9/44

VS 150

G21405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21405

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1834 Westphal Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1840 Westphal Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A Gunkel

3 (b) If veteran, name war —
3 (c) Social Security Account No. none
4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Evelyn E
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 14 1879
8. AGE: Years 65 Months 4 Days 24 If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Self

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Unknown
15. Birthplace Germany

16 (a) Informant Evelyn Gunkel
(b) Address 1840 Westphal Place
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location U.S. Md
18 (a) Funeral director Tillman Cook Inc
(b) Address 1219 Druid
OCT 9 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944 at 2 45 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Oct 8 1944 and that I last saw him alive on Oct 7 1944

Immediate cause of death	Duration
Exhaustion	2 days
Due to Pulmonary Tuberculosis	
Due to Diabetes	Indefinite
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature R E L Campbell M. D.
Address 1644 Hanover Date signed 10/8/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

837

Registered No. G21406

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 316 E Lorraine Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 E Lorraine (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma May Crosswell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Beverly
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 19 1881

8. AGE: Years: 63 | Months: 4 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: Saleswoman

11. Industry or business: Wanselow Silk Co.

FATHER
12. Name: Edmund L. Robinson
13. Birthplace: Baltimore

MOTHER
14. Maiden Name: Emma Walker
15. Birthplace: Baltimore

16 (a) Informant: Joseph R. Crosswell
(b) Address: 316 E Lorraine

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 10 1944 (month) (day) (year)
(c) Cemetery or crematory: Greenmount
Location: Balto.

18 (a) Funeral director: Wm. Cook Sons
(b) Address: Balto Md.

19 OCT 9 1944 Victor Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944 at 1:25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1935 to Oct 7 1944, and that I last saw h.. alive on Oct 7 1944.

Immediate cause of death: Left Hemiplegia — Duration: 5 day

Due to: Severe arteriosclerosis Hypertension — 15 yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Vernon H. Norwood M. D.
Address: Church Home Hospital Date signed: Oct 7 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G21407

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 325 E 29th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 325 E 29th St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ethlyn Miller Taylor

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Geo Dougal

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 18 1864

8. AGE: Years about 80 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Samuel Miller

13. Birthplace Scotland

MOTHER 14. Maiden Name Virginia Christie

15. Birthplace Scotland

16 (a) Informant Frank T Hanson

(b) Address 325 E 29th St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 10/9/44 (month) (day) (year)

(c) Cemetery or crematory Shiloh

Location Shiloh Md

18 (a) Funeral director Milhorn & Son Inc

(b) Address 1217 Park Ave

19 (a) Date rec'd by local reg. OCT 9 1944 (b) Huntington Mills Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944 at 11 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3rd. 1944 to Oct. 9th. 1944 and that I last saw h— alive on Oct. 7th. 1944

Immediate cause of death: Myocardial Insufficiency — Duration: unknown

Due to ---- --

Due to -----

Other Conditions: Arteriosclerosis — Duration: unknown

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Geo W Mungavin M. D.

Address 401 E. 25th. St. Date signed 10/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G21408 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution:
Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 141 S. Kaufman St. #29
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leroy H. Smink

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-01-8487

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Florence

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6 - 1890

8. AGE: Years	Months	Days	If less than one day
54	5	-	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Rail. Span.

FATHER
12. Name Jacob Smink
13. Birthplace Md

MOTHER
14. Maiden Name Ida Landrum
15. Birthplace Md

16 (a) Informant Florence Smink
(b) Address 141 S. Kaufman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44
(month) (day) (year)
(c) Cemetery or crematory Dolphin Cem.
Location Baltimore, Md

18 (a) Funeral director F. D. Kuppert Son
(b) Address Baltimore, Monroe St

19 (a) OCT 9 1944
(Date filed by registrar)

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/6 1944, at 8:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944, to 10/6 1944, and that I last saw h[illegible] alive on 10/6 1944.

Immediate cause of death Pulmonary Edema — Duration 12 hrs.

Due to Hypertensive Cardio-Vascular Renal Disease — Duration years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland General Hosp. Date signed 10/6/44

G21409 Grebe ✓ G21409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Mulberry & Raynor Ave
(c) Hospital or institution:
West Baltimore General Hospital V
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1926 Wilkins Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmer L. Grebe

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-01-1118

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Katherine Grebe

6 (c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) February 3-1899

8. AGE: Years 55 | Months 8 | Days 4 | If less than one day — hr. — min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Assistant Sales manager

11. Industry or business Brockagen Hill Co

FATHER
12. Name Lehar L. Grebe
13. Birthplace Maryland

MOTHER
14. Maiden Name Catherine E. Sacrowski
15. Birthplace Md

16 (a) Informant Katherine Grebe
(b) Address 1926 E Wilkins Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore and Frederick

18 (a) Funeral director F. B. Wagner & Son
(b) Address 1300 Eutaw Place

19 (a) Date received by registrar OCT 9 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944, at 6:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-30 1944, to 10-7 1944, and that I last saw him alive on 10-7 1944.

Immediate cause of death Carcinoma of Lung — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-6-44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Richard W Baldwin M. D.
Address West Baltimore General Hosp Date signed 10-7-44

a 53116 POTRZUSKI ✓

G21410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G21410

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 326 S. Chester St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theodore Potrzuski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-34

8. AGE: Years	Months	Days	If less than one day
10	5	21	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Walter Potrzuski
13. Birthplace Poland

MOTHER
14. Maiden Name Anna Leane
15. Birthplace Poland

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1944 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) (b) Huntington Wilson Registrar

OCT 9 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 26 1944 to Oct 6 1944 and that I last saw h[illegible] alive on Oct 6 1944

Immediate cause of death Respiratory arrest due to operation of brain tumor. Sutra

Due to cranial exploration revealed infiltrating blastoma

Due to this was inoperable.

Other Conditions Patient's general condition declined steadily since operation ✓
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Warren M. Weiseth M. D.
Address John Hopkins Hosp Date signed 10-6-44

WARREN M. Weiseth, M.D.

178
G21411

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

83a

Registered No. G21411

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Catonsville
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Woodlawn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2004 Thayer Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William A. Parrish
3 (b) If veteran, name war: No
3 (c) Social Security Account No. 216-01-8674
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Otelia D. Parrish
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) October 20, 1883
8. AGE: Years 60 | Months 11 | Days 18 | If less than one day ____ hr. ____ min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Stone Mason
11. Industry or business

FATHER
12. Name Frederick E. Parrish
13. Birthplace Baltimore County, Md.

MOTHER
14. Maiden Name Margaret Barkens
15. Birthplace Maryland

16 (a) Informant Mrs. Otelia D. Parrish
(b) Address 2004 Thayer Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemetery
Location Woodlawn, Md.
18 (a) Funeral director Otelia Lamoreau
(b) Address 4520 Liberty Heights Ave.
19 (a) ____ (b) ____ (Date received by registrar) Registrar

OCT 9 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8 1944 at 1:15 M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1944 to 10/8 1944 and that I last saw h____ alive on ____ 19 ____.

Immediate cause of death: Resp failure — Duration
Due to: Cerebral Hemorrhage
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Curtis Randall Jr. M. D.
Address St. Agnes Hosp Date signed Oct 8, 44

Certified by Curtis Williams, M.D.

2211 LAKE AVE

21412 ux 4936

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G21412

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 818 BURGUNDY ST

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MD (b) County

(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)

(d) Street No. 818 BURGUNDY ST. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MINNIE S. REED

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM.	WHITE	MARRIED

6 (b) Name of husband or wife EDW. H REED

6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) JUNE 6-1882

8. AGE: Years	Months	Days	If less than one day
62	4	3	hr. min.

9. Birthplace GERMANY. (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business

FATHER

12. Name LOUIS. WOLLRING

13. Birthplace GERMANY.

MOTHER

14. Maiden Name NOT KNOWN.

15. Birthplace GERMANY.

16 (a) Informant EDW. H. REED

(b) Address 818 BURGUNDY. ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 12. 44 (month) (day) (year)

(c) Cemetery or crematory LOUDON PARK.

Location BALTO MD

18 (a) Funeral director Bernard E Hanke

(b) Address 121 E West St

19 (a) OCT 9 1944 (Date rec'd by registrar) Huntington Williams H.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1944 at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 19 44 to Oct 9 1944 and that I last saw h 1 alive on 19

Immediate cause of death Uremic Coma — Duration 3 Days

Due to Nephritis

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Amelia E. Funk

Address 2211 E Lake Ave Date signed 10/9/44

VS 190

G21413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

✓ G21413

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 937 Linden ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard Fitts

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15 1885

8. AGE: Years 59 | Months 1 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ?
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va

16 (a) Informant Gladys Bonne
(b) Address 937 Linden Ave.

17 (a) Burial (b) Date thereof 10-11-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 1944 (b) Timothy for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8- 1944, at 5:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury.

23. Signature P. J. Lubinski M.D.
Medical Examiner.

Date signed 10-9-44

Per. Howard T. Wheeler, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G21414 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 DAYS

2. USUAL RESIDENCE OF DECEASED: (Mothers Address)
(a) State Md. (b) County Anne Arundel
(c) City or town Curtis Bay
(If outside city or town limits, write RURAL and give town)
(d) Street No. Curtis Bay P.O.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Albert Bartocci

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: M | 5. Color or race: Wh. | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-1-44

8. AGE: Years | Months | Days: 9 | If less than one day: hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Albert Bartocci
13. Birthplace Newark N. J.

MOTHER
14. Maiden Name Norma Hazel Coghill
15. Birthplace Baltimore Md.

16 (a) Informant Mother Mrs Norma Bartocci
(b) Address Curtis Bay P.O.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address Bath, Md.

19 (a) (Date received by registrar) (b) Registrar

OCT 9 1944

VS 180 2-44 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1944 at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1944 to 10-9 1944 and that I last saw h.i.M alive on 10-9 1944.

Immediate cause of death: Atelectasis — Duration:
Due to: Prematurity
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Burch Jr M.D.
Address 121 Light St Date signed 10-9-44

G21415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21415

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 7217 Old Harford Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7217 Old Harford Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE M. SELLERS

3 (b) If veteran, name war: --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife George Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 13, 1863

8. AGE: Years	Months	Days	If less than one day
81	6	26	hr. min.

9. Birthplace Michigan (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Morrish
13. Birthplace England

MOTHER
14. Maiden Name Smith
15. Birthplace England

16 (a) Informant Mrs. Dorothy I. Koan
(b) Address 7217 Old Harford Rd. 14

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/9/44 (month) (day) (year)
(c) Cemetery or crematory Graceland,
Location Flink, Michigan

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Signature of registrar) Registrar

OCT 9 1944
VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9, 1944, at 5:30A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 18 1942 to Oct. 9 1944, and that I last saw her alive on Sept 30 1944

Immediate cause of death: Chronic myocarditis & cerebral arteriosclerosis — Duration: 20 yrs
Due to: Hypertension
Due to:
Other Conditions: Atrophic arthritis
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Williams M.D.
Address 4706 Harford Road Date signed Oct 9 1944

G21416 ✓ G21416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 Grantley St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5653 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DORIS ANN MANNS

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Roy C. Manns, Jr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1920

8. AGE: Years	Months	Days	If less than one day
23	9	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Thomas Kreiner
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Annie May Miller
15. Birthplace Balto., Md.

16 (a) Informant Mr. Roy C. Manns, Jr
(b) Address 5753 Reisterstown Rd.

17 (a) Burial (b) Date thereof 10/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Filed (b) Huntington Williams M.D.
(Date received by registrar) Registrar

OCT 9 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1944, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1931, to 10/7 1944, and that I last saw her alive on 19.

Immediate cause of death	Duration
Coronary Thrombosis	Sudden
Due to Hypertensive Cardio Vascular Disease	13 yrs.
Due to Coarctation of Aorta.	23 yrs.
Other Conditions Congenital Heart Disease	23 yrs.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph S. Bluem M. D.
Address 606 E. Preston St. Date signed 10/9/44

G21417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21417 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St & Rutland Ave
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6

(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 N. Chester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME (William Snyder

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-03-3250

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Snyder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name —
15. Birthplace Russia

16 (a) Informant Rose Snyder
(b) Address 106 N. Chester St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-44 (month) (day) (year)
(c) Cemetery or cemetory Workmen Circle
Location Lebrey Mt Carmel

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

OCT 9 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9 1944, at 5:10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 8/29 1944 to 10/9 1944 and that I last saw him alive on 10/9 1944.

Immediate cause of death Cardio - respiratory failure — Duration

Due to Hypertensive cardio vasc. disease

Due to Uraemia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Clinical diagnosis confirmed

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Aksman M. D.
Address Sinai Hosp. Date signed 10/9/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G21418 ✓ G21418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2649 Huron St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25-3
(e) Length of stay in Baltimore (yrs., mos., or days) 1 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County Lee
(c) City or town Sumter (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Willie Lincoln
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan-29-42

8. AGE: Years 22 | Months 8 | Days 6 | If less than one day hr. min.

9. Birthplace Lee Co. S.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Willie Lincoln
13. Birthplace Sumter - S.C

MOTHER 14. Maiden Name Elizabeth Cafers
15. Birthplace Sumter - S.C

16 (a) Informant Mr. Willie Lincoln
(b) Address 2649 Huron St.

17 (a) Burial (b) Date thereof Oct 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 3221 Schroeder St

19 (a) Oct 9 1944 (b) Wilmington Williams M.D.
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 5 1944, at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944, to Oct 5 1944, and that I last saw h[illegible] alive on Oct 5 1944.

Immediate cause of death: Acute Milliary Tuberculosis — Duration 6 mo

Due to: Both Lungs.

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature R O Adams M. D.
Address 2708 Hollins Ferry Rd. Date signed 10/9/44

G21419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21419 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and name town)
(d) Street No. 1210 Booth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Morris Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 9 - 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH September 30, 1944, at 1 10 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.

Date signed Sept 30 1944

2913

G21420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

G21420 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully furnished. Please correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Joseph (Frank) Morgan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1898

8. AGE: Years	Months	Days	If less than one day
46			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 9 - 1944

18 (a) Funeral director Commissioner of Health

(b) Address Huntington Williams, M.D.

19 (a) OCT 9 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1944, at 10 10 AM

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis
Crushed leg, right

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Sept 22 1944 1912.15 10 P.M.
(b) Where did injury occur? Fayette & Calhoun Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Pedestrian struck by auto

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Sept 23 1944

2212

G21421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G21421 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison
(c) Hospital or institution: Md. Gen'l. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2823 Parkwood. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Rae

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 9/15/44

8. AGE: Years	Months	Days	If less than one day
—	—	6 days	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Mr. Robert Carroll Rae
13. Birthplace Md

MOTHER 14. Maiden Name Mrs. Mary Helen Rae
15. Birthplace Md.

16 (a) Informant Mother
(b) Address 2823 Parkwood

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 9 - 1944

18 (a) Funeral director Commissioner of Health
(b) Address 1944

19 (a) OCT 9 (Date rec'd by registrar) Huntington Hollins M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/21/1944, at 5.50 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/15/1944 to 9/21/1944, and that I last saw h[illegible] alive on 9/21/1944.

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers
Address Md. Gen'l. Hosp. Date signed 9/24/44 M. D.

2211

G21422

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G21422

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover Sts.
(c) Hospital or institution: University Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 day
(e) Length of stay in Baltimore (yrs., mos., or days) 2 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 S. Kenwood Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Boy Burgess

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	—

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/3/44

8. AGE: Years	Months	Days	If less than one day
0	0	2	hr. min.

9. Birthplace Baltimore City Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name Katherine Brissal
15. Birthplace ~~1310 Argyle St~~ Md.

16 (a) Informant Mother
(b) Address 1310 Argyle St., Baltimore

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or Location UNIVERSITY MEDICAL SCHOOL OCT 9 - 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 OCT 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/5 1944, at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944 to 10/5 1944, and that I last saw h[illegible] alive on 10/5 1944

Immediate cause of death Respiratory Failure — Duration 2 days

Due to Prematurity

Due to —

Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E. Cotral

Address University Hosp. Baltimore Date signed 10/5/44 M. D.

2214

G21423

AB-76156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G21423 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-1-& 15 26
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town) -12
(d) Street No. No Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Tall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 24-1872

8. AGE: Years	Months	Days	If less than one day
72	5	9	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business

FATHER
12. Name Thomas A. Tall
13. Birthplace Md.

MOTHER
14. Maiden Name Mary C. Poor
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals
(b) Address Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 6 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 9 - 1944 (Date rec'd by registrar) (Huntington Williams) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-3- 1944, at 1.38 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-18- 1942, to 10-3 1944, and that I last saw h im alive on 10-3 1944.

Immediate cause of death: Pneumonia & Relapse — Duration: 1 day

Due to

Due to

Other Conditions: Cardiac Failure & Latent Diabetes mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address B. C. H. Date signed 10-5-44

VS 189

2215

G21424

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21424

CERTIFICATE OF DEATH 95c Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1729 Aisquith Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1729 Aisquith St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bridget Boyd

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Daniel T. Boyd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 21 1860

8. AGE: Years 84 | Months ? | Days ? | If less than one day ########## min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Bernard Morris
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Ryan (Daughter)
(b) Address 1727 Aisquith Street

17 (a) Burial (b) Date thereof 10/10/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd. Balto; Co

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) [illegible] by me OCT 9 1944 waiting for [illegible], M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7th. 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Oct 7 1944, and that I last saw h[illegible] alive on Sept. 7 1944.

Immediate cause of death Cardiac Insufficiency — Duration 2
Due to Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Cohen M. D.
Address 1701 E North Ave Date signed 10/9/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

G21425 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6111 Eversall Ave
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCIS JOHN HALLAMEYER.

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 213-07-1841

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amanda Dell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 20, 1901

8. AGE: Years	Months	Days	If less than one day
43	1	18.	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Crane Operator

11. Industry or business: Bethlehem Steel Co.

FATHER
12. Name: George J. Hallameyer
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary E. Parr
15. Birthplace: Baltimore Md.

16 (a) Informant: Mrs. Mary E. Hallameyer
(b) Address: 1514 E. Oliver St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Rd Balto. Md

18 (a) Funeral director: George J. Ruth Inc.
(b) Address: 1735 Walbrook Ave

19 (a) OCT 9 1944 (b) (Date received by registrar) Registrar
Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8th 1944 at 3:1 M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes[5] ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 27/4
(a) Date of injury 10-7-44 at 9 P.M.
(b) Where did injury occur? above address
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? No
(d) Means of injury fell from tree to sidewalk

23. Signature: H. T. Williams M.D.
Medical Examiner.
Date signed 10-8-44

G21426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21426

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Harford Ave
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Harford Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MARY A. FROMMEYER

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex F. | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Jacob K. Frommeyer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1882

8. AGE: Years 62 | Months 1 | Days 22 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Adam Graber
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Kember
15. Birthplace Pennsylvania

16 (a) Informant Mr. Jacob K. Frommeyer
(b) Address 1612 Harford Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director George J. Ruth Inc.
(b) Address 435 Harford Avenue

19 (a) OCT 9 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1944, at 4P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
and Medical Examiner.
Date signed Oct 8, 1944

Hunterstown Williams, M.D.

G21427 Bettien ✓ G21427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balt. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4204 Massachusetts Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard L Bettien Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 6 1944

8. AGE: Years | Months 1 | Days 6 | If less than one day hr. min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Richard L Bettien

13. Birthplace D. C.

MOTHER 14. Maiden Name Mary E McDermott

15. Birthplace Ft Mc Henry Md

16 (a) Informant Mrs R L Bettien

(b) Address 4204 Mass Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (Month) (day) (year)

(c) Cemetery or crematory Carlton Mem Estates

Location Balt Md

18 (a) Funeral director Geo A Fuhrman

(b) Address Fulton & Fayette

19 (a) OCT 9 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/44 19 , at 8:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7/44 19 , to 10/8/44 19 , and that I last saw him alive on 10/8/44 19 .

Immediate cause of death	Duration
Acute Respiratory Failure	
Due to Congenital Abnormality	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Acute pulmonary congestion

of autopsy Cardiac hypertrophy, patent foramen ovale

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis L Grumbine M. D.

Address Date signed

G21428

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G21428

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cost of age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 832 N. Lakewood
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Herold Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-18-4302A

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-78

8. AGE: Years	Months	Days	If less than one day
74	3	3	hr. min.

9. Birthplace Chezo (Town, county, and state)

10. Usual Occupation Butcher

11. Industry or business

FATHER 12. Name John Herold

13. Birthplace Chezo

MOTHER 14. Maiden Name Angela Cita

15. Birthplace Chezo

16 (a) Informant Records

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek

(b) Address 2601 E. Madison Street

19 (a) OCT 9 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1944 at 6.35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 16 1944 to Oct 7 1944 and that I last saw deceased on Oct 7 1944

Immediate cause of death Toxemia — Duration 2 weeks

Due to Decubitus Ulcers — 3 weeks

Due to Fracture of Neck of Femur

Other Conditions Pneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence Sept. 16, 1944 (month) (day) (year)
(c) Where did injury occur? Eastern Ave. Broadway (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Public Place (Specify type of place) while at work? No
(e) Means of injury Slipped + fell on street

23. Signature Wm. C. Woods Jr. M.D.

Address Johns Hopkins Hospital Date signed 10/7/44

For, D.H.L. Wallenweber, by Howard J. Worthington M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21429 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St and Rutland Ave
(c) Hospital or institution:
Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 32 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs 32 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia County Wise
(c) City or town East Stone Gap.
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(e) Citizen of foreign country? (If rural give location) No. (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE CAUDILL
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	SINGLE

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 27th 1939

8. AGE: Years	Months	Days	If less than one day
5	7	11	hr. min.

9. Birthplace Arno, Virginia (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name James F. Caudill
13. Birthplace Kentucky

MOTHER
14. Maiden Name Judah Caudill
15. Birthplace Kentucky

16 (a) Informant James F. Caudill
(b) Address East Stone Gap, Virginia

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13, 1944 (month) (day) (year)
(c) Cemetery or crematory East Stone Gap Cem.
Location East Stone Gap Virginia

18 (a) Funeral director Lasley Mem. Funeral Home
(b) Address 7401 Belair Road

19 Oct 10 1944 Huntington Williamson W Va

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8 1944, at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1944, to Oct. 8 1944, and that I last saw h/m alive on Oct. 8 1944.

Immediate cause of death ALEMIA — Duration

Due to APLASTIC ALEMIA

Due to

Other Conditions Lung ABSCESS
Thrombocytopenia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: APLASTIC ANEMIA

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Simson M.D.
Address Sinai Hospital Date signed 10/9/44

C21430

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1640

Registered No. C21430

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 928 Wilmot Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wilmer F. Lutz

3 (b) If veteran, name war W —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) ~~Single~~, married, ~~widowed, or divorced~~. Married

6 (b) Name of ~~husband or~~ wife Carrie Lutz

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25th 1901

8. AGE: Years 42 | Months 11 | Days 23 | If less than one day hr. min.

9. Birthplace Vineland N.J.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Katz

FATHER
12. Name William T. Lutz
13. Birthplace N.J.

MOTHER
14. Maiden Name Emma Brand
15. Birthplace Balto. Md.

16 (a) Informant Carrie Lutz
(b) Address 921 Wilmot Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore, Md.

18 (a) Funeral director Tillery Funeral Home
(b) Address 2117 Pennsylvania Ave

19. (a) OCT 10 1944 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 8 - 1944, at 2.20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-8- at P M.
(b) Where did injury occur? N.J. Police Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Suspended by belt

23. Signature Howard J. Weaklees M.D.
Medical Examiner.

Date signed 10-9-44

G21431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G21431

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caroline & Oliver Sts.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Woodlea Avenue Roomer
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Tillie Akehurst 10/7/44

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 9 | 16 | 1859

8. AGE: Years: 85 | Months: 0 | Days: 21 | If less than one day: hr. min.

9. Birthplace: Baltimore Co. Md. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Richard H. Akehurst
13. Birthplace: Md.

MOTHER
14. Maiden Name: Julia A. Rill
15. Birthplace: Md.

16 (a) Informant: Mrs. David King
(b) Address: Washington D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olivet
Location: Baltimore, Maryland

18 (a) Funeral director: Tillson Cook, Inc.
(b) Address: 1217 N. Paul Street

19 (Signature and title): Huntington Williams M.D. Registrar

OCT 10 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/7 1944 at 8:45 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 30 1944 to 10/7 1944 and that I last saw h[illegible] alive on 10/5 1944.

Immediate cause of death: Hypostatic Pneumonia — Duration
Due to: Fracture of Rt. Hip.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident
(b) Date of occurrence: September 29 1944 at 5 P. M
(c) Where did injury occur? 4109 Woodlea Avenue (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. While at work? No. (Specify type of place)
(e) Means of injury: Fell down stairs striking head on floor.
23. Signature: Malvin Jamarche
Address: St. Joseph's Hospital Date signed 10/9/44 M.D.

Approved: 10/9/44 H. L. Wolff Jacobs M.D. per Robert de Graban M.D.

G21432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21432 Registered No. 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4107 West View Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4107 Westview Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grant Henry Shepherd

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ora Shepherd
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 26 1867

8. AGE: Years 76 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Concord Ohio (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name John Shepherd
13. Birthplace Ohio

MOTHER
14. Maiden Name Helen Russell
15. Birthplace Ohio

16 (a) Informant R J Shepherd
(b) Address 4107 Westview Rd

17 (a) Disposition (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director Miller & Cook Inc
(b) Address 1217 Eutaw St

19 (a) Filed OCT 10 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944 at 2 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1924 to Oct 8 1944, and that I last saw ~~deceased~~ alive on Oct 8 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: 10 days
Due to: Arterio-Sclerosis — Duration: Indefinite
Due to: Hypertension
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W H Woodey M. D.
Address 1403 Park Ave Date signed 10/10/44

G21433

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30E

Registered No. G21433

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 428 Ilchester Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (3)
(If outside city or town limits write RURAL and give town)
(d) Street No. 428 Ilchester Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie C. Holbrunner

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color of race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Thomas A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 20 1894

8. AGE: Years 50 | Months 3 | Days 17 | If less than one day hr. min.

9. Birthplace: Clear Spring Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Harry C Robison
13. Birthplace: Md

MOTHER
14. Maiden Name: Laura V. Groh
15. Birthplace: Md

16 (a) Informant: Thomas A Holbrunner
(b) Address: 428 Ilchester Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville Md

18 (a) Funeral director: Tillman Lodge Inc
(b) Address: 1217 E Pratt St

19 (a) [illegible] (b) Huntington Williams 117 [illegible]
(Date received by local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1940 to Oct 7 1944 and that I last saw her alive on Oct 7 1944

Immediate cause of death: Uraemia Hunt
Disease

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 5 years

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Geo. Sawyer M.D.

Address 4808 Harford Rd Date signed 10/8/44

G21434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G21434

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the CAUSE of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Greene
(b) Street address Lombard & Redwood Sts
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Bayard St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent (Miller) MILAUSKAS

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Adella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 30 1884

8. AGE: Years 59 | Months 9 | Days 6 | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)

10. Usual Occupation Tailor

11. Industry or business

FATHER
12. Name Joseph Milauskas
13. Birthplace Lith ?

MOTHER
14. Maiden Name
15. Birthplace Lith

16 (a) Informant Adella Milauskas
(b) Address 917 Bayard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Beland Rd

18 (a) Funeral director Joseph Kasmakas Son
(b) Address 6 E Washington St Huntington Indiana, Ind.

OCT 10 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 1944, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6 1944 to Oct. 6 1944, and that I last saw h. alive on October 4 44.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Arterial hypertension

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry W. Hollis
Address University Hospital Date signed 10/6/44

VS 150 For S.H.L. McCammon, by Howard J. Mahaffey, M.D.

G21435

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21435

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/26/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 8/26/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. 1638 N. Cadwalder Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME JOSEPH HAMILTON

3 (b) If veteran, name war
3 (c) Social Security Account No. 167-18-0699

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: --
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 10, 1907
8. AGE: Years 37 | Months 3 | Days 10 | If less than one day hr. min.
9. Birthplace New York City (Town, county, and state)
10. Usual Occupation Merchant Seaman
11. Industry or business

FATHER
12. Name Edward Hamilton
13. Birthplace Cincinnati, Ohio

MOTHER
14. Maiden Name Carolina Schneeman
15. Birthplace Long Island, N. Y.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ (month) (day) 1944 (year)
(c) Cemetery or crematory Holy Sepulchre
Location Philadelphia Penna.
18 (a) Funeral director Lilly & Zeller Co.
(b) Address 4503 N. Wolf St.

OCT 10 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Oct. 8, 1944 at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 26, 1944 to Oct. 8, 1944 and that I last saw him alive on Oct. 8, 1944

Immediate cause of death: Pulmonary hemorrhage — Duration: First noticed about May 1944.

Due to: Bronchiogenic carcinoma of the left lung with multiple metasteses

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation: Bronchoscopy-5/12/44

Major findings of operation: Possible bronchogenic carcinoma, left lung.

Autopsy: As above

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis F. Cleary M. D.
Address Baltimore, Md. Date signed 10/9/44

G21436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21436
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Glyndon Ave #23
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Mrs. Martha E. Urban

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Max Urban

6 (c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Dec 20, 1884

8. AGE: Years: 59 | Months: 9 | Days: 18 | If less than one day: ..... hr. ..... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Carl Domeike
13. Birthplace: Germany

MOTHER
14. Maiden Name: Henrietta Tepple
15. Birthplace: Germany

16 (a) Informant: Mr. Max Urban
(b) Address: 1312 Glyndon Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct 12 · 1944 (month) (day) (year)
(c) Cemetery or crematory: Western
Location: City

18 (a) Funeral director: Mr.-Mrs. John W. Teufelsdorf
(b) Address: 801 W. Lafayette St.

19 (a) (If dead brought in) Received OCT 10 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1944, at 3:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944, to 10/9 1944, and that I last saw her alive on 10/8 1944

Immediate cause of death: Probable Pulmonary Thrombosis — Duration: .....

Due to: Bilateral Thrombophlebitis — Duration: 1 wk.

Due to: ..... — Duration: .....

Other Conditions: Diabetes Mellitus — Duration: ..... years

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Martin E. Strobel
Address: Maryland General Hospital signed M. D. 10/9/44

Huntington Williams, M.D.

G21437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 557

G21437 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1135 Cleveland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A. Bell

3 (b) If veteran, name war: no

3 (c) Social Security Account No. 705-09-1800

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida May.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-24-1889

8. AGE: Years 55 | Months 8 | Days 14 | If less than one day 16 hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business B. O. R. R.

FATHER 12. Name William H Bell

13. Birthplace Md.

MOTHER 14. Maiden Name Elmina FLAYHART

15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12. 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St

19 (a) (Date received by registrar) OCT 10 1944 (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1944 at 12.56 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 5 1944 to Oct 9 1944, and that I last saw him alive on Oct. 9 1944.

Immediate cause of death: Respiratory Failure — Duration: 2 days

Due to: Squamous cell carcinoma 4 mos

Due to: Abortion with metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. Iverson M. D.
Address 760 Hilton Date signed Oct 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21438 BALTIMORE CITY HEALTH DEPARTMENT G21438
CERTIFICATE OF DEATH 97 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2612 N. Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 N. Charles St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Roberts Stone
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: Wm. F. Stone
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1856
8. AGE: Years 88 | Months 1 | Days 4 | If less than one day hr. min.
9. Birthplace Balto., Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER 12. Name Alfred Roberts
13. Birthplace England
MOTHER 14. Maiden Name Mary E. Bardle
15. Birthplace Md.

16 (a) Informant Wm. Fistone Jr
(b) Address 4911 Falls Road Terrace
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem. Co.
Location E. end of North ave.
18 (a) Funeral director John Mitchell & Sons
(b) Address 400 Eutaw Place
19 (a) (b) (Undertaker or Agent) Registrar

OCT 10 1944
VS 180 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944, at 2 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from 1-1-1940 to Oct 8 1944, and that I last saw h alive on Oct 8 1944.

	Duration
Immediate cause of death: Myocardial failure	2 days.
Due to:	
Due to: Arteriosclerosis	—
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Howard H. Warner M. D.
Address 2604 Garrison Blvd Date signed 10-8-44

G21439 (1)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 61

G21439
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3319 Sun St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5/1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3319 Sun St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hattie Wright

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 27 1895

8. AGE: Years 49 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Gilbert Ringwater

13. Birthplace Ga.

MOTHER 14. Maiden Name Unknown

15. Birthplace

16 (a) Informant Frank Wright

(b) Address 3319 Sun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10/44 (month) (day) (year)

(c) Cemetery or crematory F.H.B. Calvary Cem.

Location A. A. County, Md.

18 (a) Funeral director Mrs Robert A. Elliott, Dpt

(b) Address 1129 N. Caroline St.

OCT 10 1944 (a) (Date rec'd by registrar) (b) Tunstall Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1944, at 1 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1944, to Oct. 7, 1944, and that I last saw h[illegible] alive on Oct. 6 1944.

Immediate cause of death	Duration
Diabetes Mellitus	2 years
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature McDonald Bando M. D.

Address 2405 O'Hill Ave. Date signed 10-9-44

G21440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G21440

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 104 E. Mulberry St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 E. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Randall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31, 1884

8. AGE: Years 60 | Months 6 | Days 8 | If less than one day ... hr. ... min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Joanna Johnson
(b) Address 104 E. Mulberry St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem
Location Frederick Rd

18 (a) Funeral director Mrs. Robert A. Elliott & Dpt.
(b) Address 1129 N. Carrollton Ave.

OCT 10 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8th 1944, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1944 to Oct 7 1944, and that I last saw her alive on Oct 7 1944.

Immediate cause of death	Duration
Lobar pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roald Blighston M.D.
Address 2129 Druid Hill Ave. Date signed 10/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21441 ✓ G21441

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 403 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) No
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Boyle, Sr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mary E. Willson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 24, 1869

8. AGE: Years 74 | Months 10 | Days 13 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Police Officer

FATHER 12. Name David A. Boyle

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name —

MOTHER 15. Birthplace Ireland

16 (a) Informant Mrs. Thomas Boyle

(b) Address 935 Elm Ridge Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 10/44. (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd

18 (a) Funeral director Henry H. Kirby Inc

(b) Address 4101 Edmondson Ave

19 OCT 10 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7/44. 19 , at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1944 to Oct 6 1944 and that I last saw h[im] alive on Oct 6 1944

Immediate cause of death Cerebral Hemorrhage | Duration 7 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. P. Vansant Shelpman M. D.

Address 416 Edmondson Ave Date signed 10/10/44

G21442

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21442

CERTIFICATE OF DEATH

157M

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3519-4th St., 4 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Dorothy May Covey

If U.S. Veteran specify WAR

(a) Residence: No. 3519-4th St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Fem	W	Single

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of —

6. DATE OF BIRTH (month, day, year) 10/2/44

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		3 hrs	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Nil

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) 3519-4th St Balto Md

FATHER

13. NAME Gordon E Covey

14. BIRTHPLACE (city or town) (State or country) Harford Co Md

MOTHER

15. MAIDEN NAME Alberta F Benson

16. BIRTHPLACE (city or town) (State or country) Balto Md

17. INFORMANT (Address) Gordon E Covey 3519-4th St (25)

18. BURIAL, CREMATION, OR REMOVAL Place UNIVERSITY MEDICAL SCHOOL Date OCT 6 — 1944, 19

19. UNDERTAKER Commissioner of Health (Address)

20. FILED OCT 10 1944 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 10/2, 1944

22. I HEREBY CERTIFY. That I attended deceased from 19 to 19

I last saw h alive on 10/2, 1944 Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

Prematurity. — Date of onset

Other contributory causes of importance:

Was an operation performed? Date of

For what disease or injury?

What test confirmed diagnosis? None Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? If so, specify

(Signed) C. E. Whelan M. D.

(Address) 1229 Mulberry St

2216

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G21443 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Riverside Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4/5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 RIVERSIDE AV
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Henry L. Theis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alice Theis

6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov. 16, 1880

8. AGE: Years 63 Months 10 Days 8 If less than one day hr. min.

9. Birthplace Maryland (town, county and state)

10. Usual Occupation Shoe Mender

11. Industry or business

FATHER
12. Name Henry L. Theis
13. Birthplace Md.

MOTHER
14. Maiden Name Mary McNamee
15. Birthplace Md.

16 (a) Informant Daughter Mrs. Jansen
(b) Address 1010 Riverside Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Bel-Air Rd. City

18 (a) Funeral director John R Kenny
(b) Address 1242 Leeds Ter. Halethorpe

19 (a) (Date received by Registrar) OCT 20 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 19 44 at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from August 19 44 to Oct 15 19 44 and that I last saw h[illegible] alive on 10/15 1944.

Immediate cause of death: Carcinoma of oesophagus — Duration 4 mos.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
Signature Isaac Miller M. D.
Address [illegible] Dearborn St. Date signed 10/16/44

G21444

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G21444
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Eaton avenue
(c) Hospital or institution: Jenkins Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2943 N. Charles St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henrietta Hess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 11, 1872

8. AGE: Years 72 | Months 6 | Days 28 | If less than one day hr. min.

9. Birthplace Harmony (Town, county, and state)

10. Usual Occupation Housekeeper

11. Industry or business

FATHER
12. Name John Hess
13. Birthplace Harmony

MOTHER
14. Maiden Name Catherine Strohlefeather
15. Birthplace Harmony

16 (a) Informant Jenkins Memorial Hospital
(b) Address 1000 Eaton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Wm. J. Tickner & Son
(b) Address Balto. Md.

19 (a) (Date rec'd by registrar) OCT 10 1944 (Registrar) Huntington Williams

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1944, at 7:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1, 1944, to Oct. 9, 1944, and that I last saw h.r. alive on October 8, 1944.

Immediate cause of death: Respiratory failure

Due to: Cerebral

Due to: Hypertensive Cardio Vascular Disease & Auricular Fibrillation

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Bryan M. D.
Address Date signed 10-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

G21445

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G21445

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2324 Herkimer St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2324 Herkimer St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME LAURA AMELIA BUCHMASTER

3 (b) If veteran, name war: None
3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James J.
6 (c) If alive, give age 1878 ~~1878~~ years

7. Birth date of deceased (mo., day, yr.) Nov. 23, ~~1878~~

8. AGE: Years	Months	Days	If less than one day
~~87~~ 64	10	14	hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John R. Buchmaster
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Betters
15. Birthplace Md.

16 (a) Informant Mr. James J. Buchmaster
(b) Address 2324 Herkimer St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 10 1944 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7, 1944, at 8:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Oct 7 1944 and that I last saw h[illegible] alive on Oct 7 1944.

Immediate cause of death: Acute Pulmonary Edema — Duration: 1 week

Due to: Hypertension C.V.D. — 2 years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul Schaffer
Address 2301 Annapolis Rd. Date signed 10/9/44

(OVER)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21446 — 937 — Registered No. 21446

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1632 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1632 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE ELIZABETH NAGLE

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1865

8. AGE: Years	Months	Days	If less than one day
79	4	2	hr. min.

9. Birthplace Accomac Co., Va. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Thomas Willett
13. Birthplace Accomac Co., Va.

MOTHER
14. Maiden Name Elisha Bell
15. Birthplace Accomac Co., Va.

16 (a) Informant Mrs. Bertie Chambers
(b) Address 1632 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by registrar OCT 10 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1944, at 5:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1944, to Oct 5 1944, and that I last saw h[illegible] alive on Oct 8 1944.

Immediate cause of death	Duration
Cardiac Asthma	24 hrs.
Due to Cardio Vascular during.	5 yrs
Due to Hypertension Cerebral Hemorrhage	5 yrs 1 week
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature E. W. Koons
Address 806 N Fulton Ave Date signed 10/9/44

E. W. Koons

G21447 ✓ G21447

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKING UNAUTHORIZED ALTERATIONS RESERVED FOR BLANKING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 23 W Parish St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 23 W Parish St. (If outside city or town limits, write RURAL and give town)
(d) Street No. Baltimore, Md (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME George Delaney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Male	Colored	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10, 1880

8. AGE: Years	Months	Days	If less than one day
63	4	28	hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name George Delaney
13. Birthplace Va

MOTHER 14. Maiden Name Bookes
15. Birthplace Va.

16 (a) Informant George Delany Jr
(b) Address 231 Parish St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory Ashula
Location Virginia

18 (a) Funeral director Mrs Kate B. Wyelia
(b) Address 3221 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 10 1944

VS 126

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944 at 11:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1944 to Oct 8 1944 and that I last saw h[illegible] alive on Oct 8 1944.

Immediate cause of death	Duration
Lobar Pneumonia	1 Week
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature R. W. Rentschler M.D.
Address 426 N. Johns Date signed 10/10/44

G21448

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21448 Registered No. 13/a

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Dimm St
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Amity Alley St (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Jones

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Annie King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877 Sept 25

8. AGE: Years 65 | Months 66 | Days 19 | 18 | If less than one day hr. 13 min.

9. Birthplace Warrington, N.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Shipyard Worker

FATHER
12. Name Nelson Jones
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Mason
15. Birthplace Warren Co. N.C.

16 (a) Informant Mary Sledge
(b) Address 524 W. Barre St Balto

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by Registrar) (b) Oct 10 1944 Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944 at 2:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 7 1944 and that I last saw h[illegible] alive on Oct 7 1944

Immediate cause of death Uremia — Duration

Due to Cardio Vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest A. Hug

Address Univ Hosp Date signed Oct 7

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21449 ✓ G21449 Registered No.

G21449 48 D

PLACE OF DEATH:
Baltimore City, Maryland
(a) Street address 729 Baker St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 729 Baker St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mueded E. Moorhead

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rufus Moorhead
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) June 13, 1900

8. AGE: Years 44 | Months 2 3 | Days 26 25 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Tildow
13. Birthplace Balto Md.

MOTHER
14. Maiden Name Effie J. Williams
15. Birthplace Howard Co. Md.

16 (a) Informant Rufus Moorhead
(b) Address 729 Baker St

17 (a) Burial (b) Date thereof Oct 10, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Aberdeen, Md.
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) ____ (b) ____
(Date rec'd by registrar) Registrar

VS 150 OCT 10 1944 Huntington-Williams, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 19 44, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 28 19 44 to Oct 8 19 44 and that I last saw her alive on Oct 8 19 44.

Immediate cause of death: Carcinoma of Uterus

Duration: 4 mo's

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1928 Penna Ave Date signed 10/9/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct, age in especially important. Physicians: please write the causes of death clearly and legibly.

G21450

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21450 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2242 Cecil Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 2242 Cecil Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Lester

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 73+ | Months — | Days — | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business School teacher

FATHER
12. Name Thomas Lester
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sarah Symmes
15. Birthplace Ireland

16 (a) Informant Miss Delia Slater
(b) Address 2242 Cecil Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Wyckoff
(b) Address 501 E 22nd St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180 OCT 10 1944 Hunter for Hillenbeck

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/9/1944 at 6P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Oct 10 1944 and that I last saw her alive on Sept 10 1944

Immediate cause of death	Duration
Myocardial Insufficiency	1 mo
Due to Generalized Arteriosclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas F. Mackie M. D.
Address 582 E. 22nd St Date signed 10/10/44

G21451

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G21451

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division
(c) Hospital or institution: Provident
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2231 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Esther Baskerville

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race wht | 6 (a) Single, married, widowed, or divorced. Smith

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4 — 1 — 1903

8. AGE: Years 41 | Months 6 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation School Teacher

11. Industry or business

FATHER
12. Name Henry H. Baskerville
13. Birthplace Whitestone, Va

MOTHER
14. Maiden Name Ella C. Pitts
15. Birthplace Accomac Co Va

16 (a) Informant Mrs Ella Baskerville
(b) Address 2231 Madison ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk
Location Balto Co

18 (a) Funeral director J. L. Chester Loudjimy
(b) Address 579 Mosher St

OCT 10 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 — 6 — 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1944, to 10-6 1944 and that I last saw her alive on 10-6 1944

Immediate cause of death	Duration
Right Hemiplegia	
Due to Essential Hypertension	
Due to Cerebral Accident	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. W. Baltz M. D.
Address 2033 Druid Hill Ave Date signed 10/9/44

G21452 — BALTIMORE CITY HEALTH DEPARTMENT — Registered No. G21452

CERTIFICATE OF DEATH 139a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Dennison St
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1546 Penn. Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Hardy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Negro	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 13, 1901

8. AGE: Years	Months	Days	If less than one day
43	10	25	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER 12. Name ? Williams
13. Birthplace Va

MOTHER 14. Maiden Name Missouri Rose
15. Birthplace Va

16 (a) Informant Robert Hardy
(b) Address 1546 Pennsylvania Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/10/44 (month) (day) (year)
(c) Cemetery or crematory McKenney, Va
Location Va

18 (a) Funeral director Rev. G. Nelson
(b) Address 1303 Presstman St

19 (a) (Signature and address of local registrar) Huntington Williams, M.D. Registrar
OCT 10 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-8-1944, at 1:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6-1944 to 10-8-1944 and that I last saw her alive on 10-8-1944.

Immediate cause of death	Duration
Pulmonary Abscess	
Due to	
Due to	
Other Conditions Secondary Cancer	

(Include pregnancy within 3 months of death)
Date of operation 10-7-44
Major findings of operation: appendix
1 quart of suppuration
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Robt Johnson M. D.
Address Provident Hosp Date signed 10-10-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MARGIN RESERVED FOR BINDING

G21453

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1462

G21453 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1101 E. Arlington Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1101 E. Arlington Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mattie M. Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 3, 1885

8. AGE: Years 59 | Months 6 | Days 4 | If less than one day hr. min.

9. Birthplace New Castle, Del. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name James Sanders
13. Birthplace Del.

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrs. Naomi Stewart
(b) Address 1101 E. Arlington Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-10-44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 3 OCT 10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1944 at 3:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/7 1944, to 10/7 1944, and that I last saw h alive on 19

Immediate cause of death: Coronary Thrombosis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

Signature Ben Roberts M. D.
Address Date signed

G21454 BALTIMORE CITY HEALTH DEPARTMENT G21454
AB-90055 CERTIFICATE OF DEATH 518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 St. Marys Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Murdock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22-1869

8. AGE: Years 74 | Months 10 | Days 15 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jim Murdock 'D'
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Johnson 'D'
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Ffances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Date received by registrar) OCT 10 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1944, at 9.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1944 to 10-7 1944, and that I last saw him alive on 10-7 1944

Immediate cause of death Kidney failure & uremia — Duration 2-4 hrs

Due to Ca of Prostate & metastases — 1-2 years

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature O. R. Cutler
Address Balt City Hosp Date signed 10-9-44

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 150

G21455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G21455 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address East 33rd St

(c) Hospital or institution: The Union Memorial Hospital 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo, 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 61 yrs, 2 mo, 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore City

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4502 Main Field Ave
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mrs Johanna C. Thompson Beck

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Mr William Henry Beck

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) August 6, 1883

8. AGE: Years	Months	Days	If less than one day
61	2	3	____ hr. ____ min.

9. Birthplace Baltimore City
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mr John Thompson

FATHER 13. Birthplace Germany

MOTHER 14. Maiden Name Augusta Kreiger

MOTHER 15. Birthplace Germany

16 (a) Informant Mr. William Henry Beck

(b) Address 4502 Mainfield Ave

17 (a) Burial (b) Date thereof 10-12-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Parkwood

Location Baltimore

18 (a) Funeral director Lionel D. Lask

(b) Address 5305 Harford Rd.

19 (a) ____ (b) ____
(Dep't'd by) (Address)

OCT 10 1944

VS 196

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1944, at 5:10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from ~~Sept 24~~ 1944, to October 7, 1944, and that I last saw her alive on October 9, 1944.

Immediate cause of death	Duration
Carcinoma of the stomach with metastases to mesentery and liver	8 months
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature John D. Morris M. D.

Address 1 W Mt. Date signed Oct 9, 1944

G21456

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH ✓ 83a

Reg. Dist. No. .....

G21456

1. PLACE OF DEATH:
Baltimore
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
3507 Belstan Drive
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3507 Belstan Drive
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME MAY R. TAYLOR
3. (b) Social Security Number .....

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Herbert A. Taylor
6.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.) May 1, 1876

8. AGE: Years 68 | Months 5 | Days 5 | If less than one day: ..... hrs. ..... min.

9. Birthplace Ravenna, Ohio
(Town, county, and state)
10. Usual occupation House wife
11. Industry or business .....
FATHER 12. Name John Richardson
13. Birthplace Ravenna, Ohio
MOTHER 14. Maiden name Ann Herriff
15. Birthplace Ravenna, Ohio
16. Informant Herbert A. Taylor
Address 3507 Belstan Drive, Baltimore, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 9. 44 (month) (day) (year)
Cemetery or crematory Memorial Park Cemetery
Location Frederick, Md.
18. Funeral director Gladhill Co.
Address Middletown, Md.
19. OCT 10 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 6 19 44 at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 3 19 44 to Oct 6 19 44
and that I last saw h. alive on Oct 5 19 44
Immediate cause of death ..... Cerebral Hemorrhage | DURATION 3 days.
Due to ..... |
Due to ..... |
Other conditions ..... |
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op. .....
Autopsy results ✓
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE A. P. VanSchaick, Md.
M. D. or other
Address 4818 Edmondson Date signed Oct 6, 1944

C21457

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 94a

Registered No. C21457

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd. Street
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford
(c) City or town Havre de Grace (If outside city or town limits, write RURAL and give town)
(d) Street No. 226 S. Washington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles L. Drennen

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary E. Drennen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 6, 1880

8. AGE: Years 64 | Months 2 | Days 3 | Unless less than one day hr. min.

9. Birthplace Rising Sun, Maryland (Town, county, and state)

10. Usual Occupation Barber

11. Industry or business

FATHER
12. Name Elias H. Drennen
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Stewart
15. Birthplace Md.

16 (a) Informant Mary E. Drennen
(b) Address 226 S. Washington St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18 (a) Funeral director Pennington & Son
(b) Address Havre de Grace, Md.

19 (a) Date received OCT 10 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1944, at 8:45 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐, and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed October 15, 1944.

VS 151

G21458

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G21458

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give postal)
(d) Street No. 4107 Old North Point Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Eagan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Frank Eagan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15, 1847

8. AGE: Years	Months	Days	If less than one day
97	4	24	hr. min.

9. Birthplace New Jersey (Town, county and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Roland
13. Birthplace Ireland

MOTHER
14. Maiden Name Eliz. Glynn
15. Birthplace Ireland

16 (a) Informant Frank Eagan
(b) Address 682 Valley St

17 (a) Burial (b) Date thereof 10-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Johns Cem
Location Arabia N J

18 (a) Funeral director Guy C Hawley
(b) Address Fulton & Fayette

19 OCT 10 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1944 at 4:53 P. M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of femur

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 3/1944 M.
(b) Where did injury occur? 4107 Old North Point Rd.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Fell down stairs.
23. Signature H. J. Wollenweber M.D.
Medical Examiner.
Date signed October 10, 1944.

G21459

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312a

Registered No. G21459

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 28 S. Washington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 S. Washington St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine (or) Josie (or) Josephine R. Albert

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife John

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) June 26, 1876

8. AGE: Years 68 Months 3 Days 12 If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Thomas Rahleder
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Yearichen
15. Birthplace Baltimore, Md.

16 (a) Informant John Albert
(b) Address 28 S. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) Address Lombard & Ann Sts.

OCT 10 1944 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1944 at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 3 1943 to Oct. 8 1944, and that I last saw h[illegible] alive on Oct. 8 1944.

	Duration
Immediate cause of death: Myocardial Insufficiency	12 days
Due to: Hypertension & Arteriosclerosis	2 yrs.
Due to: Chronic Nephritis	about 3 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John V. Rahleder M. D.
Address 1902 Eutaw Pl. Date signed 10-9-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G21460 — BALTIMORE CITY HEALTH DEPARTMENT — G21460

CERTIFICATE OF DEATH 131a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert st -
(c) Hospital or institution Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mos.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County St. Mary's
(c) City or town Oakley (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Dent
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	M.

6 (b) Name of husband or wife Mr. J. M. Dent -
6 (c) If alive, give age 68 years
7. Birth date of deceased (mo., day, yr.) 11-3-1888.

8. AGE: Years	Months	Days	If less than one day, hr.	min.
66	11	20?		18?

9. Birthplace Oakley, Md. (Town, county and state)
10. Usual Occupation housewife -
11. Industry or business

FATHER 12. Name
13. Birthplace Unk.

MOTHER 14. Maiden Name Unk.
15. Birthplace

16 (a) Informant Mrs. C. H. Camalier
(b) Address Leonardtown, Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)
(c) Cemetery or crematory All Saints
Location Oakley, Md.

18 (a) Funeral director W. C. Mattingley Sons
(b) Address Leonardtown, Md.

19 (a) Date received by local registrar 10 1944 (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1944 at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h.er alive on 10-9 1944.

Immediate cause of death resp. failure — Duration

Due to uremic poisoning

Due to Chr. nephritis

Other Conditions hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. William F. Osborne M. D.
Address Mercy Hosp. Date signed 10-10-44

G21461

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G21461 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Mercy Hospital 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 157 East St Second floor
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Bayler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lena Baylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Laborer (auto service Man)

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Lena Bayler
(b) Address 157 East St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bryant St ave

19 (a) (Date rec'd by registrar) (b) Registrar
OCT 10 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1944, at 1:55 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pneumonia, lobar, right

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
For Medical Examiner.
Date signed October 10 1944.

G21462

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G21462 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1612 Hanover St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life -

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 923 Hanover St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Anna M. Randall

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Edward T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1890

8. AGE: Years 54 | Months 4 | Days 20 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Joseph FUKA
13. Birthplace Bohemia

MOTHER
14. Maiden Name Mary DUSEK
15. Birthplace Bohemia

16 (a) Informant Thomas M. Randall
(b) Address 923 Hanover St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12/1944 (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem.
Location A.G. Co., Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St.

19 (a) (b) Registrar

OCT 10 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8, 1944 at 10:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Oct 8 1944 and that I last saw h[illegible] alive on - 10/8 1944

Immediate cause of death - Hypostatic Pneumonia — Duration 2 days

Due to - Myocarditis — 1 mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. M. Bellis M. D.
Address 1029 William St Date signed 10/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21463

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93 D

G21463 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 McPhail St. (If rural give location)
(e) Citizen of foreign country? No, (Yes or No) If yes, name country

3 (a) FULL NAME Harry Hook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed.

6 (b) Name of husband or wife Late Laura A. (Burned)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1881

8. AGE: Years	Months	Days	If less than one day
63	3	9	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER: 12. Name — Hook
13. Birthplace Unknown

MOTHER: 14. Maiden Name "
15. Birthplace "

16 (a) Informant Albert Warfield
(b) Address 144 Paterna Ave. Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17/44 (month) (day) (year)
(c) Cemetery or crematory Morgan Chapel
Location Florence Md

18 (a) Funeral director Harry H. Writzle
(b) Address 440 Edmondson Ave

19 (d) OCT 10 1944 (Date rec'd by registrar) Huntingtor Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1944, at 2:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1944, to 10-10 1944, and that I last saw h Live alive on 10-10 1944

Immediate cause of death Coronary Occlusion — Duration

Due to Hypertensive Cardiovascular Disease

Due to Hypertension

Other Conditions Pulmonary Congestion

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: Coronary Occlusion

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Patricia Dodd
Address Univ. Hospital Date signed 10/10/44 M. D.

G21464

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G21464
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Don
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 W. Allegheny Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GORDON Bennet PROPF

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Lillian C.

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Aug 25 1897

8. AGE: Years 47 | Months 1 | Days 10 | If less than one day: hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Reporter (Newspaper)

11. Industry or business Sun

FATHER
12. Name Henry
13. Birthplace Md.

MOTHER
14. Maiden Name Jeanette Homerick
15. Birthplace Md.

16 (a) Informant Lillian C.

(b) Address 25 W. Penn, Towson, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)

(c) Cemetery or crematory Mt Moriah

Location Towson Md

18 (a) Funeral director John G Moran

(b) Address 3000 E Balt St

OCT 10 1944 (b) (Date rec'd by registrar) Hamilton Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 7 1944, at 10 P. M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.

Date signed 10-7-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21465

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21465 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 232 S. Exeter St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 42 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 S. Exter St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Antonio Frezza

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-10-7555

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of wife Rosina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4 1884

8. AGE: Years 60 | Months 8 | Days 4 | If less than one day hr. min.

9. Birthplace Larino Italy
(Town, county, and state)

10. Usual Occupation Shoemaker

11. Industry or business

FATHER
12. Name Gaetano Frezza
13. Birthplace Italy

MOTHER
14. Maiden Name Leonilde De Simone
15. Birthplace Italy

16 (a) Informant Rosina Frezza Wife
(b) Address 232 S. Exeter St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt. Md.

18 (a) Funeral director Frank Della Rocca
(b) Address 52 N. Morley St.

19 (a) OCT 10 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8, 1944, at 3:53 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1, 1943, to October 8 1944, and that I last saw him alive on Octob. 8, 1944.

Immediate cause of death: Broncho-Pneumonia — Duration: 1 week
Due to: Congestive Heart Failure — 1 day
Due to: Arteriosclerosis — Unknown
Due to: Cerebral Hemorrhage — 1 year, 5 months
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Philibert Artigiani
Address 2942 E. Fayette St. Date signed M. D. 10/9/44

Sliwka

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. C21466 / 94a

C21466

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 416 S. Register St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Register St
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alexander Sliwka

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years: about 61 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation: Retired

11. Industry or business

FATHER
12. Name: Stanislaw Sliwka
13. Birthplace: Poland

MOTHER
14. Maiden Name: Jozefa Wisniewska
15. Birthplace: Poland

16 (a) Informant: Anna Sliwka
(b) Address: 416 S. Register St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-13-44 (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: Germain Hill Rd.

18 (a) Funeral director: Wm. L. Fialkowski
(b) Address: 2007 Eastern Ave

19 (a) (Date received) OCT 10 1944 Huntingtown, Md. (Registrar's signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 9, 1944, at 7 P. M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept. 30 to Oct. 9, 1944, and that I last saw him alive on Oct. 9, 1944

Immediate cause of death: Coronary Thrombosis — Duration: a few hrs.

Due to: Coronary Heart Disease — Duration: 2 yrs.

Due to: Hypertension

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Isaac J. Jenkins M. D.
Address: 700 E. Fratt St. Date signed: 10/9/44

G21467

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21467

Registered No. 46587 1160a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Ward or address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 10

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 718 Aisquith St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fred Hess

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9-25-44

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business

FATHER 12. Name Fred Hess
13. Birthplace ?

MOTHER 14. Maiden Name Pauline —
15. Birthplace ?

16 (a) Informant Ricords
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS HOSP'L SCHOOL OCT 10 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 10 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29 1944 at 10 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1944 to Sept 29 1944 and that I last saw h[illegible] alive on Sept 29 1944

Immediate cause of death: Cerebral hemorrhage & concussion

Due to: Cerebral injury

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Clifton O. Larson M. D.
Address Johns Hopkins Hosp. Date signed

2220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

621468

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 621468

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6914 Homeway Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph W. Lutz

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed or divorced: Married

6 (b) Name of husband or wife: Estelle Lutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 8, 1875

8. AGE: Years: 69 | Months: 9 | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Engineer
11. Industry or business Crosse & Blackwell

FATHER
12. Name Daniel Lutz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Estelle Lutz
(b) Address 6914 Homeway Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12/47
(month) (day) (year)

(c) Cemetery or crematory Lakewood Cem.
Location Baltimore, Md.

18 (a) Funeral director Philip Henry Stone
(b) Address 2046 Orleans St

19 (a) OCT 10 1947 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1947, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary occlusion
Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed Oct. 10, 1947.

G21469

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G21469
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 432 Aisquith St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 432 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C	Widowed

6 (b) Name of husband or wife Mary (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 11, 1886

8. AGE: Years	Months	Days	If less than one day
58	7	26	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Janitor
11. Industry or business

FATHER
12. Name Richard Smith
13. Birthplace Md

MOTHER
14. Maiden Name ?
15. Birthplace Md

16 (a) Informant Thelma Smith Costello
(b) Address 1021 Wilcox St

17 (a) Burial (b) Date thereof 10/11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md

18 (a) Funeral director Joseph G. Locke
(b) Address 1204 N. Central Ave

19 (a) [illegible] 1944 (b) [illegible]
(Signature of registrar) (Date received)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/7/1944, at 6 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1944, to Oct 7th 1944, and that I last saw h[illegible] alive on Oct 7th 1944.

Immediate cause of death	Duration
Pneumonia, Lobular	
Due to Uremia	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Mary G. Fry M. D.
Address 116 Aisquith St Date signed 10/10/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FO[illegible] BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21470

BALTIMORE CITY HEALTH DEPARTMENT G21470 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2812 Northern Pkwy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) NN
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2812 Northern Pkwy (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Kleiderlein
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex male
5. Color or race white
6 (a) Single, married, widowed, or divorced. widowed
6 (b) Name of husband or wife Sophia
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 8 1854
8. AGE: Years 90 Months 10 Days - If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business
FATHER 12. Name John Kleiderlein
13. Birthplace Germany
MOTHER 14. Maiden Name Katherine Lire
15. Birthplace Germany
16 (a) Informant Mrs. Frederick Finke
(b) Address 2812 Northern Pkwy
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore
18 (a) Funeral director Leonard J. Kuck
(b) Address 5305 Harford Rd
19 (a) Registrar
OCT. 10 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 — 1944 at M
21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Oct 8 1944 and that I last saw h~~im alive~~ on Oct 8 1944

	Duration
Immediate cause of death Uremic Myocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Hyland Kelley M. D.
Address 5703 Harford Rd Date signed 10/10/44

G21471 dup

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G21471 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 40 E. 25th St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 40 E. 25th St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Margaret S. Wolfe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife William Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 7th 1867

8. AGE: Years	Months	Days	If less than one day
77	9	2	hr. min.

9. Birthplace Hopewell Pa (Town, county, and state)
10. Usual Occupation At home
11. Industry or business Self

FATHER
12. Name Henry Simon
13. Birthplace Phila Pa.

MOTHER
14. Maiden Name Amanda Ritz
15. Birthplace Pa

16 (a) Informant Guy S. Wolfe
(b) Address 25th St. Paul St

17 (a) Removal (Burial, cremation, removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Shepherdstown W. Va
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 Washington Blvd

OCT 10 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9th 1944 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Oct 9 1944 and that I last saw him alive on Oct 9 1944.

Immediate cause of death	Duration
Acute Cardiitis	4 years
Due to Infection	4 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
25. Signature Hubert M. Foltz M. D.
Address 2824 St. Paul St Date signed Oct 10-44

VS 180

G21472

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21472 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Belloua Av
(c) ~~Hospital or~~ institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 508 E. 35th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie V. Ross

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, ~~married~~, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband ~~or wife~~ George W. Ross

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27th 1866

8. AGE: Years	Months	Days	If less than one day
78	8	11	hr. min.

9. Birthplace Queen Annes Co. Md. (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business Self

FATHER
12. Name John Wallace
13. Birthplace Md.

MOTHER
14. Maiden Name Josephine Booker
15. Birthplace Md.

16 (a) Informant Wallace V. Ross
(b) Address 508 E. 35th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory Sudlersville
Location Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (a) 1944 (Date rec'd by registrar) (b) Lester Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8th 1944 at 11 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/26 1944 to 10/8 1944, and that I last saw h. ~~or~~ alive on 10/8 1944.

Immediate cause of death	Duration
Cerebral Hemmorhage	12 days
Due to Arteriosclerosis	unknown
Due to -----	
Other Conditions ------	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Jas. W. Jeffries attending MD
Address 401 E. 25th. St. Date signed 10/10/44

G21473

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21473 / 122B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 626 Oldham Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Joan Crump

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14, 1944

8. AGE: Years | Months: 5 | Days: 27 | If less than one day: 26 hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph John Crump
13. Birthplace Lenore, N. C.

MOTHER
14. Maiden Name Emma Mae Melton
15. Birthplace Lenore, N. C.

16 (a) Informant: Mr. Joseph John Crump
(b) Address 626 Oldham St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Hillis Lamborn
(b) Address 1005 W. Baltimore St.

OCT 10 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1944, at 8 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intestinal Obstruction.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenweber M.D. Medical Examiner.
Date signed October 10, 1944.

G21474

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

G21474

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2423 Dennison St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2423 Dennison St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Staerker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Catherine A. Staerker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 27, 1890

8. AGE: Years	Months	Days	If less than one day
53	11	11	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Bethlehem-Steel Co.

FATHER
12. Name Charles Staerker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary England
15. Birthplace Baltimore, Md.

16 (a) Informant Miss Mary Catherine Staerker
(b) Address 2120 N. Wolfe St.

17 (a) Burial (b) Date thereof Oct. 12, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cemetery
Location Baltimore, Md.

18 (a) Funeral director Phillip Lawrence
(b) Address 4510 Liberty Heights Ave.

19 (a) (b) at
(Date filed by registrar) Registrar

10 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH October 8 1944, at 11.50P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944 to Oct 8 1944, and that I last saw h. alive on Oct 7 1944.

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions Chr Bronchitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 hrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel L Gruss M. D.
Address 1261 E. North Ave. Date signed 10/9/44

G21475

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21475

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2737 Fenwick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2737 Fenwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harrison H. Geumann

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Elizabeth V.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27th 1874

8. AGE: Years	Months	Days	If less than one day
70	8	13	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired Postal Clerk

11. Industry or business U. S. Government

FATHER
12. Name Henry Geumann
13. Birthplace Germany

MOTHER
14. Maiden Name Louisa Lambach
15. Birthplace Germany

16 (a) Informant Elizabeth Geumann
(b) Address 2737 Fenwick Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Balto Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 OCT 11 1944 (Date received by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10th 1944, at 8:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1-1943 to 10-10-1944 and that I last saw him alive on 10-10-1944.

Immediate cause of death: Coronary occlusion — Duration: 1 year

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo B. Dyer M. D.
Address 402 Harford Rd Date signed Oct 20 44

VS 180

G21476

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21476
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 Elliott St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maryanna Lewkiewicz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Poland

16 (a) Informant Hosp. Records
(b) Address

17 (a) Burial (b) Date thereof 10-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Fialkowski
(b) Address

OCT 11 1944

19 (a) (Date rec'd by registrar) (b) Hunting for Williams Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1944, at 5:50 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Arteriosclerosis
Cardiovascular
Due to disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Henry L. Hollenweber, M.D.
Medical Examiner.
Date signed Oct. 10 1944
Con. Howard J. Williams M.D.

G21477

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21477 / 1312

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Brendan Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town 3503 Brendan Ave
(If outside city or town limits, write RURAL and give town)
(d) Street No. Balto
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisa C. Simmons.

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Stephen Simmons

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 21 1879

8. AGE: Years 66 70 | Months — | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Anton Menecke
13. Birthplace Germany

MOTHER
14. Maiden Name Dorothea
15. Birthplace Germany

16 (a) Informant Mrs Emma Lumbin
(b) Address 3503 Brendan Ave

17 (a) Burial (b) Date thereof Oct 11th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Arlington Ave

19 (a) ____ (b) ____
(Date received by Registrar) (Registrar)

OCT 11 1944

VS 150

Hunting for Hist

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944, 2:55 PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Oct 8 1944 and that I last saw him alive on Oct 8 1944

Immediate cause of death

Cardiac Vascular disease — Duration 1 yr

Due to

Due to Chronic Nephritis — 1 yr

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Gray M.D.
Address 6727 North Ave Date signed 10/8/44

(over)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G21473 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2106 Orleans St
(c) Hospital or institution: 6-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Orleans (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Mary Kathryn Lipple

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1915

8. AGE: Years	Months	Days	If less than one day
29	3	2	..... hr. ..... min.

9. Birthplace Altoona Pa (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business

FATHER
12. Name Anthony Lipple
13. Birthplace Pa

MOTHER
14. Maiden Name Caroline O'Connor
15. Birthplace Pa

16 (a) Informant Anthony Lipple
(b) Address 2601 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto

18 (a) Funeral director Leitch Funeral Home
(b) Address 2008 Orleans St

19 (a) OCT 11 1944 (Date received by registrar) (b) Registrar Huntington

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10th 1944 at 5-20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944, to Oct 10 1944, and that I last saw h[illegible] alive on Oct 10 1944.

Immediate cause of death	Duration
Pulmonary Embolism	30 hrs
Due to Rheumatic C.V. Disease	
Due to	
Other Conditions Auricular Fibrillation, Mitral Stenosis	

(Include pregnancy within 3 months of death)

Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature John F. Casalahan M.D.
Address 24 N. Fulton Ave Date signed 10/10/44

G21479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G21479 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution 700 Fleet Street 16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1209 Whatcoat St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmonia Randolph Rooney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lillian Smith (sister in law)
(b) Address 1204 Laurens St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director J. A. Brooks
(b) Address 1437 N. Carey St

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) OCT 11 1944 (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1944, at 11:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Dulaney M.D.
Medical Examiner.
Date signed Oct. 10, 1944.

G21480

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 96

G21480 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 9/24/44 12
(e) Length of stay in Baltimore (yrs., mos., or days) Since 1914

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 N. Howard Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME ROGER EUGENE PAYNTER

3 (b) If veteran, name war: World's War
3 (c) Social Security Account No. 216-03-6969
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mildred Tracy
6 (c) If alive, give age: 42 years
7. Birth date of deceased (mo., day, yr.): Mar. 12, 1892
8. AGE: Years 52 | Months 6 | Days 8 | If less than one day 27 hr. min.
9. Birthplace: Mechanicsville, Md. (Town, county, and state)
10. Usual Occupation: Auto Mechanic
11. Industry or business: -

FATHER
12. Name: Thomas Paynter
13. Birthplace: Caledonia, Md.

MOTHER
14. Maiden Name: Julia Elson
15. Birthplace: Caledonia, Md.

16 (a) Informant: Records, U.S.Marine Hosp.
(b) Address: Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)
(c) Cemetery or crematory: Balto National
Location: Frederick Ave

18 (a) Funeral director: A. Lee Ader
(b) Address: 6447 York Road.

19 (a) OCT 11 1944 (Date rec'd by registrar) (b) Hunting for Military

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH October 8, 1944 at 5:12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept.24, 1944 to Oct.8, 1944, and that I last saw h im alive on Oct. 8, 1944.

Immediate cause of death: Acute thrombosis posterior descending branch left coronary artery — Duration: Sev.days prior to admiss.
Due to: Generalized arteriosclerosis with arteriosclerotic aneurisms ~~xxxx~~ in the right common and external iliac arteries. — Unk.
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation: None
Major findings of operation:
of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: No
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: Louis F. Clancy M. D.
M.E. Address: Baltimore, Md. Date signed 10/9/44

Va-14567

G21481 G21481

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1325 E. FAYETTE ST
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 1
(e) Length of stay in Baltimore (yrs., mos., or days) 39 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 1325 E. FAYETTE ST (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE ZABLONSKY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife MORRIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name HARRY
13. Birthplace RUSSIA

MOTHER
14. Maiden Name MIRIAM
15. Birthplace RUSSIA

16 (a) Informant AL ZABLONSKY
(b) Address

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location 7414 RD. & HAMILTON AVE

18 (a) Funeral director Jack Louis Inc.
(b) Address 1439 E. Balto. St.

19 (a) OCT 11 1944 Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10-44 19.., at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 12 1944 to Oct 10 1944, and that I last saw her alive on Oct 8 1944.

Immediate cause of death Carcinoma of Ovary — Duration 7-1-43

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation Oct 6 1944

Major findings of operations Carcinoma Ovary

of autopsy? No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Not
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. S. Shortt M. D.
Address 6210 York Rd Date signed Oct 10 1944

Huntington Williams M.D.

G21482

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124 B

G21482 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 37 S. Henrietta St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2352
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town 31 S. Henrietta St. (If outside city or town limits, write RURAL and give town)
(d) Street No. E. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas Chrisakos

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M. | 5. Color or race W | 6 (a) Single, married, ~~widowed, or divorced~~:

6 (b) Name of husband or wife Violet Chrisakos
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 15 1894

8. AGE: Years 50 | Months 5 | Days 23 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Candy store
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Nick Karangelos
(b) Address 36 Williams St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1944 (month) (day) (year)
(c) Cemetery or crematory Forest Cem. Evergreen
Location Baltimore, Md.

18 (a) Funeral director J. Francis Reese
(b) Address Undertaker

19 (a) OCT 11 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944, at 10 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1943 to Oct 8 1944, and that I last saw him alive on Oct 8 1944

	Duration
Immediate cause of death: Terminal Bronchopneumonia	2 dys.
Due to: Portal Cirrhosis of Liver	1 yr.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: none.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph N. Zeller M. D.
Address 231 E. Eutaw Place Date signed 10/9/44

G21455

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

G21483

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere - Green Spring Ave
(c) Hospital or institution: Hebrew Home for Aged 2
5-6-25
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL, and give town)
(d) Street No. Belvedere Ave - Green Spring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SOLOMON KASSANOVSKY

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Leah

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1846

8. AGE: Years 98 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Abraham Morris -

13. Birthplace Russia

MOTHER 14. Maiden Name Minnie -

15. Birthplace Russia

16 (a) Informant Morris Katzow

(b) Address 3514 Ellamont Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Isaac Levine Sons

(b) Address 173 E. Balto. St.

19 OCT 11 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1944, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1940, to 10-10 1944, and that I last saw h[illegible] alive on 10-10 1944.

Immediate cause of death Bron-pneumonia

Second degree burns.

Arteriosclerosis, Hypertension

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide Accident 2/7/17

(b) Date of occurrence Oct. 6 1944 at M

(c) Where did injury occur? Belvedere & Green Spring Ave. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home for aged (Specify type of place) While at work? No

(e) Means of injury Scalded in bath tub

23. Signature H. Edmund Levin M.D.

Address Lansdale Date signed 10/10/44

Approved: Robert Le Fretais M.D.
Oct. 11 1944

G21484

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 176

G21484 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Balto., Md.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Barney Levy

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-0517

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Goldie nee Fichter
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Manchester, England (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Jargel
13. Birthplace Russia

MOTHER 14. Maiden Name Bessie
15. Birthplace Russia

16 (a) Informant Goldie Levy
(b) Address 2405 W. North Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-11-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Joel Levin Inc
(b) Address 1139 E. Balto St
10-11-1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1944, at 4:05 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pneumonia Lobular.

Due to Contusion of head and neck.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-7-44 at 4/1 M.
(b) Where did injury occur? 225 W. Balt St
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work?
(d) Means of injury Fall down elevator shaft

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)
Date signed Oct. 10, 1944.

VS 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21485

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 938

G21485 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2001 Greenberry Rd.
(c) Hospital or institution: at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 2715
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2001 Greenberry Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Eva Barnitz Hamilton

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Jas. Hamilton
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 10 1854

8. AGE: Years 90 | Months 9 | Days 0 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER — 12. Name Alex. H. Barnitz
13. Birthplace Maryland

MOTHER — 14. Maiden Name Amelia Whitmarsh
15. Birthplace Maryland

16 (a) Informant Douglas Hamilton (Son)
(b) Address 2001 Greenberry

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY (F. A. Mowen Sub.)
(b) Address 100 E. North Avenue

19 (a) OCT 11 1944 (Date filed by Registrar) (b) — Registrar

VS 150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1944 at 1:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1940 to Oct 10 1944, and that I last saw her alive on Oct 9 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 2 da.

Due to: Cardio-vascular disease — Duration: 2

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operations: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Douglas Hamilton

Address 846 W 36th St. Date signed 10/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21486

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 94a

G21486 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1534 Park Ave.
(c) Hospital or institution: 14 H

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
Street No. 1534 Park Ave (If rural give location)
(d) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert T. Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Jessie M
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8 1874

8. AGE: Years	Months	Days	If less than one day hr.	min.
70	7	23		

9. Birthplace Raleigh NC (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name Robert Jones
13. Birthplace N Car

MOTHER
14. Maiden Name Lucretia Mills
15. Birthplace N Car

16 (a) Informant Jessie M. Jones
(b) Address 1534 Park Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory
Location Wash D.C.

18 (a) Funeral director
(b) Address Wm Chambers Co

19 (a) Wash. (b) D.C.
Received by Local Reg. OCT 11 1944 Huntington Harrison, M.D.
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1944, at 8:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 14, 1944, to Oct. 10, 1944, and that I last saw him alive on October 10 44.

Immediate cause of death: Coronary occlusion — Duration 48 hrs.

Due to: Coronary sclerosis and generalized arteriosclerosis.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation: None.

Major findings of operation:

of autopsy: None.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thos. G. Hayes M. D.
Address 11 E. Chase Street Date signed Oct. 11 1944

G21487

(B-69560)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G21487

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1mos-11days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1830 Eagle St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Wright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Effie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 25- 1874

8. AGE: Years	Months	Days	If less than one day
70	7	14	hr. min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Harry Wright (D)
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Chamberlain (D)
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Hattie R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 11 1944 (Date received by registrar) Huntington Williams, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 -9- 1944, at 1.15A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8 -28- 1944 to 10 -9- 1944 and that I last saw h im alive on 10- 9- 1944

Immediate cause of death: Bronchopneumonia — Duration 1 day

Due to: Cardiac Decompensation

Due to:

Other Conditions: Enlarged Prostate 5 wks
c Urinary Obstruct
(Include pregnancy within 3 months of death)

Date of operation: no

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S. P. Akasra M. D.
Address 4940 Eastern Ave Date signed 10-9-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21488

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1706

Registered No. G21488

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 4 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dom
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 666 Vine St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES F. JOHNSON

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles F Johnson
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Alice Simms
15. Birthplace Md

16 (a) Informant Daisy Henderson
(b) Address 826 Edmondson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 11 1944 (Date rec'd by registrar) (b) Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944, at 1 45 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-8-44 at 1:30 A. M. 17/3
(b) Where did injury occur? Franklin & Ogden Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? —
(d) Means of injury Pedestrian struck by auto
23. Signature J. L. Wollenweber M.D. Medical Examiner.
Date signed 10-8-44

G21489

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21489 Registered No. 1328

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2523 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2523 W. North Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME WILLIAM HENRY THOMAS

3 (b) If veteran, name war	3 (c) Social Security Account No.
World War I	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Emma E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1897

8. AGE: Years	Months	Days	If less than one day
46	10	19	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Operator
11. Industry or business Balto. Transit Co.

FATHER
12. Name Benjamin Thomas
13. Birthplace Lusby's, Calvert Co., Md.

MOTHER
14. Maiden Name Mary Bafford
15. Birthplace Calvert Co., Md.

16 (a) Informant Mrs. Emma E. Thomas
(b) Address 2523 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/11/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received OCT 11 1944 (b) Registrar Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 8, 1944, at 10:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1940 to Oct 8 1944 and that I last saw h[illegible] alive on Oct 1 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration 7 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M W. Jacobson M. D.
Address 1600 N. Charles St Date signed 10-12-44

G21490

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21490 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Greenway Apts. (If institutional, give usual location)
(e) Citizen of foreign country United States (Yes or No)
If yes, name country

3 (a) FULL NAME MR. EPHRIAM Edwin LEACH.

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Marion Edna Leach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1874.

8. AGE: Years	Months	Days	If less than one day
70	1	13	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Proprietor
11. Industry or business E. E. Leach-Pattern Makers

FATHER
12. Name Charles W. Leach
13. Birthplace Md.

MOTHER
14. Maiden Name Emma V. Crumbacker
15. Birthplace Md.

16 (a) Informant Dr. C. Edward Leach
(b) Address 17 Southfield Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem. Location Pikesville, Md.

18 (a) Funeral director W. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Huntington Willis Registrar

OCT 11 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10- 1944, at 5:45A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1944, to 10-10 1944, and that I last saw him alive on 10-9- 1944.

	Duration
Immediate cause of death: Intracerebral hemorrhage.	6 days.
Due to: Arteriosclerotic hypertensive cardiovascular disease.	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. K. Palmer M. D.
Address University Hospital Date signed 10-10-44

G21491

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 170 C

G21491
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Dead
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Chinaco
(If outside city or town limits, write RURAL and give town)
(d) Street No. 614 Patapsco Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA MARIBEAN CALLENDAR

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14, 1941

8. AGE: Years 3 | Months 0 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Matthew Callender
13. Birthplace Large, Pisua.

MOTHER
14. Maiden Name Ida Hewitt
15. Birthplace Sparrows Point, Md.

16 (a) Informant Matthew Callender
(b) Address 614 Patapsco Ave, Chinaco Park

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11, 1944 (month) (day) (year)

(c) Cemetery or crematory Asbury
Location Pennsville, Md.

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light St.

19 (a) OCT 11 (Date received by registrar) (b) 64 Hunting for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9 1944 at 6 15 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-9-44 at — P M.
(b) Where did injury occur? Baltimore County Patapsco Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Pedestrian struck by auto

23. Signature 74 W Callender M.D.
Attending Medical Examiner.
Date signed 10-9-44

G21492

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1226

Registered No. G21492

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: Church Home + Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2804 Goodwood Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ella Messick

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: not known Longe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1872

8. AGE: Years 72 | Months 5 | Days 11 | If less than one day hrs. min.

9. Birthplace Balt. Maryland (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Heath
13. Birthplace Maryland

MOTHER
14. Maiden Name Dickenson
15. Birthplace Maryland

16 (a) Informant Mrs. G. Samuel Messick Son
(b) Address 2804 Goodwood Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Balto County

18 (a) Funeral director George J. Ruth Inc
(b) Address 1738 Edmondson Ave

19 (a) OCT 11 1944 (Date received by registrar) Huntington Williamson, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1944 at 8:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 10 1944
and that I last saw h.er alive on Oct 10 1944

Immediate cause of death Heart failure

Duration

Due to Myocardial Degeneration

Due to Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 9/13/44

Major findings of operation: Appendicitis, Gangrenous appendix, Peritonitis, Ruptured appendix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marvin W Davis M. D.

Address Church Home Date signed 10-10-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully prepared. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21493

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G21493 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 East 25th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 East 25th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Minton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife William J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1871 ~~1869~~

8. AGE: Years 73 ~~75~~ | Months | Days | If less than one day hr. min.

9. Birthplace Ireland (Town, county and state)

10. Usual Occupation at home

11. Industry or business

FATHER 12. Name Michael Keaver

FATHER 13. Birthplace Ireland

MOTHER 14. Maiden Name Anne Waters

MOTHER 15. Birthplace Ireland

16 (a) Informant William Minton

(b) Address 1702 East 25th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location Baltimore

18 (a) Funeral director Leonard J. Ruck

(b) Address 530 Harford Road.

19 (a) OCT 11 1944 (Date rec'd by Registrar)

Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11th 19 44 at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9.23.44 19 to 10.11 19 44 and that I last saw h. alive on 10.11 19 44

Immediate cause of death	Duration
Uremia	1 week
Due to Generalized arteriosclerosis - Chronic Nephritis	many
Due to Cardiac Hypertension	Known
Other Conditions Blind.	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Edward Norris M. D.

Address 107 East west st Date signed 10/12/44

G21494

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21494 Registered No.

JO #99853

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 4-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 E. Baltimore St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Haskamp

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 12, 1875

8. AGE: Years	Months	Days	If less than one day
69	3	28	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Antone Haskamp (d)
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ? (d)
15. Birthplace Germany

16 (a) Informant Records, Baltimore City Hospit
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)
(c) Cemetery or crematory Moreland Park
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Road

19 (a) (Date rec'd by Registrar) OCT 11 1944 (b) Thurlow [illegible]

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1944 at 4:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18, 1944, to Oct. 10, 1944, and that I last saw h. 1m alive on Oct. 9, 1944.

Immediate cause of death	Duration
Bronchopneumonia	6 days
Due to Hypostatic Congestion	
Congestive heart failure	?
Due to Chronic Valvular Heart Disease	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature D. M. Phillips M. D.
Address Bal. City Hosp. Date signed 10-10-44

331876

G21495

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21495
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 529 N. Dallas St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles H. Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-18-01

8. AGE: Years	Months	Days	If less than one day
43	3	23	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER
12. Name Rosa Young.
13. Birthplace Md.

MOTHER
14. Maiden Name Caroline ?
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 14 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cemetery
Location A A Co. Md

18 (a) Funeral director Robert Mehlenbacher
(b) Address 15 15 McElderry St

19 (a) (b)
(Date received by registrar) Registrar

OCT 11 1944
vs 1

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944 at 9 45 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1944 to Oct 11 1944, and that I last saw h[illegible] alive on Oct 11 1944.

Immediate cause of death	Duration
Renal insufficiency	
Due to Hypertensive cardiovascular disease	
Due to Arteriolar sclerosis of kidneys	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed Oct 11 44
Huntington Williams, M.D.

G21496

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

G21496
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Essex (If outside city or town limits, write RURAL and give town)
(d) Street No. 153 Riverside Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harman Ray Swiger

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Mrried

6 (b) Name of husband or wife: Freeda Swiger

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): apr.25,1910

8. AGE: Years 34 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace: West Virginia (Town, county, and state)

10. Usual Occupation: Machinest

11. Industry or business

FATHER
12. Name: Rufus Swiger
13. Birthplace: West Va.

MOTHER
14. Maiden Name: Ida Hudson
15. Birthplace: West Va.

16 (a) Informant: Freeda Swiger
(b) Address: 157 Riverside Rd. Essex

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/ 14/44 (month) (day) (year)
(c) Cemetery or crematory: Salem, West Va.
Location:

18 (a) Funeral director: Lilly & Custer Inc.
(b) Address: 403 S. Wolfe Street

19 (a) (Date received by registrar) OCT 11 1944 Burial Permit Issued by Registrar, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1944, at 1 M

21. I certify that I took charge of the remains described above, held an Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent Meningitis

Due to Fracture of skull

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 25/6
(a) Date of injury September 24 1944 M.
(b) Where did injury occur? Bethlehem Fairfield Shipyards
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury: Struck by falling object

23. Signature: Robert Lee Graham M.D. Medical Examiner.
Date signed October 11 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21497

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21497 Registered No. 1335

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. The correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3406 Hayward Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3406 Hayward Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Amola Pohlman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	W.

6 (b) Name of husband or wife John M. Pohlman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1872

8. AGE: Years	Months	Days	If less than one day
72	5	13	hr. min.

9. Birthplace Frizzburg Carroll Co, Md. (town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER	12. Name Jacob Yingling
	13. Birthplace Frizzburg, Carroll Co. Md
MOTHER	14. Maiden Name Azilla Taylor
	15. Birthplace Carroll Co. Md

16 (a) Informant Mr. John M. Pohlman
(b) Address Reisterstown, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)
(c) Cemetery or crematory Lutheran Cemetery
Location Reisterstown Md

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) OCT 11 1944 Registered by
(b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1944 at 12 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 18 1940 to Oct 9 1944 and that I last saw h[illegible] alive on July 21 1944

Immediate cause of death: Polycystic Tumor of Left Kidney — Duration: 4 years
Due to
Due to
Other Conditions Senility
(Include pregnancy within 3 months of death)
Date of operation no operation
Major findings of operations
of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joshua H. Amoss M.D.
Address 6419 Windsor Mill Road Date signed Oct 9 1944

VS 350

affirmed by Howard J. Mellin, M.D. Baltimore - 7 Maryland

G21498 G21498

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 2 days
(e) Length of stay in Baltimore (yrs., mos., or days): 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Florida (b) County:
(c) City or town: Coral Gables (If outside city or town limits, write RURAL and give town)
(d) Street No.: 3700 Harlano St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3 (a) FULL NAME: Mrs. Margaret Ryman

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife:
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1890

8. AGE: Years: 54 | Months: 5 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: John Dryhie
13. Birthplace: Scotland

MOTHER
14. Maiden Name: Margaret McDonald
15. Birthplace: Scotland

16 (a) Informant: Hospital Records
(b) Address:

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof: Oct 10/44 (month) (day) (year)
(c) Cemetery or crematory: Brownsville Texas
Location: Brownsville Texas

18 (a) Funeral director: Ullrich Funeral Home
(b) Address: 2008 Orleans St

OCT 11 1944 (Date received) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 11 1944, at 2:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1944 to 10-11 1944, and that I last saw h[illegible] alive on 10-11 1944.

	Duration
Immediate cause of death (?) Coronary occlusion	four minutes
Bronchial asthma, acute	
Due to Bronchial asthma, chronic	6 yrs.
Due to (?) due to chronic asthma	(?)
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation: —
Major findings of operation: —
of autopsy: Emphysema of lungs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: —
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Mann W. Davis M. D.
Address: [illegible] Date signed: 10-11-44

G21499

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21499

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Relay (If outside city or town limits, write RURAL and give town)
(d) Street No. 5100 Viaduct Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry E. Baquol

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Bessie Baquol
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 4, 1893

8. AGE: Years	Months	Days	If less than one day
51	6	6	hr. min.

9. Birthplace Md. (Balto.) (Town, county, and state)
10. Usual Occupation Mechanic
11. Industry or business Westinghouse Elec. Co.

FATHER
12. Name Charles J. Baquol
13. Birthplace Paris, France

MOTHER
14. Maiden Name Sophie Walther
15. Birthplace Md. (Balto.)

16 (a) Informant Mr. Charles J. Baquol
(b) Address 147 Siegwart Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem. Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1944 (Filed) (b) Huntington Mills

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1944 at 7:10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1944 to 10-10 1944, and that I last saw h/ alive on 10-10 1944.

Immediate cause of death Coma
† Respiratory Failure — Duration

Due to Cerebral Hemorrhage

Due to Mediastinal Lymphosarcoma

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Above findings

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William J. Bryan M. D.
Address St. Agnes Hosp. Date signed 10-11-44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21500

Registered No. G21500

G21500

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1736 Thames Ave (If rural, give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country

3 (a) FULL NAME Charles W. Skipper

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Julia Skipper
6 (c) If alive, give age ~~187~~ 76yrs

7. Birth date of deceased (mo., day, yr.) Aug 29, ~~1867~~ 1868

8. AGE: Years	Months	Days	If less than one day
68 ~~76~~	1	12	____ hr. ____ min.

9. Birthplace Maryland (Balto.)
(Town, county, and state)
10. Usual Occupation Grand Lecturer
11. Industry or business Grand Lodge, Masons

FATHER
12. Name John Skipper
13. Birthplace Maryland (Balto.)

MOTHER
14. Maiden Name Mary Dorman
15. Birthplace Maryland

16 (a) Informant Mr. Edward M. Skipper
(b) Address 6004 W. Rogers Ave. 15

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 (Date received by registrar) (b) Huntington Williams M.D. Registrar

PLEASE WRITE PLAINLY, WITH UNFADING INK. Please write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1944, at 4 00 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8- 1944, to 10-11 1944, and that I last saw h~~im~~er alive on 10-11 1944.

Immediate cause of death	Duration
Cardiac failure	4 days
Due to Myocardial infarction	4 days
Due to Arteriosclerotic heart disease	several years
Other Conditions Uremia, benign prostatic hypertrophy, pulmonary congestion	

(Include pregnancy within 3 months of death)

Date of operation ———
Major findings of operation: ———
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marvin H. Davis M. D.
Address Church Home Date signed 10-11-44

VS 180

(over)

G21501

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21501 Registered No.

G21501

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address NORTH BROADWAY
(c) Hospital or institution: CHURCH HOME & HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 DAYS.
(e) Length of stay in Baltimore (yrs., mos., or days) LIFETIME.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town CATONSVILLE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 105 HILTON, AVE.
(If rural give location)
(e) Citizen of foreign country? DO (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH KELLER HAMILTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W	WIDOW

6 (b) Name of husband or wife PETER HAMILTON

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-9-1856

8. AGE: Years	Months	Days	If less than one day
85	1	1	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER | FATHER

12. Name WILLIAM KELLER

13. Birthplace SCOTLAND.

14. Maiden Name HELEN MUIRHEAD

15. Birthplace SCOTLAND.

16 (a) Informant MRS. E. H. DUNN

(b) Address 105 HILTON AVE, CATONSVILLE, MD.

17 (a) Burial (b) Date thereof 10/12/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director Wm. J. Tichenor & Son

(b) Address Balto., Md.

19 (a) (b) Registrar
(Date filed by registrar)

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 10 1944, at 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5 1944, to 10-10 1944, and that I last saw her alive on 10-9 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Arteriosclerotic heart disease.	
Due to	
Other Conditions Diabetes, duodenal obstruction	

(Include pregnancy within 3 months of death)

Date of operation 10-5-44

Major findings of operation: abdominal adhesions

of autopsy: Lobular pneumonia, fatty liver, kidneys, other

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M.

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Charles Stevens Hatch, MD
M. D.

Address Church Home Hospital Date signed 10/10/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item is important. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G21502

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21502 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1010 Webb Court
(c) Hospital or institution Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 Webb Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Avon Orem Foreman

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 217 - 09 - 3043

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: n.m.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 11, 1914

8. AGE: Years 30 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Cockeysville, Md.
(Town, county, and state)

10. Usual Occupation Driver

11. Industry or business Tidewater Express

FATHER
12. Name Harry A. Foreman
13. Birthplace Cecil Co., Md.

MOTHER
14. Maiden Name Isabel Orem
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Harry A. Foreman
(b) Address 1010 Webb Court, Balto., Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10 1944, at 3:30 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Hemorrhage

Due to Chronic pulmonary Tuberculosis

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct 11 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGINS RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21503

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21503 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4230 Loch Raven Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4230 Loch Raven Blvd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Dr. Henry Albert McMains

3 (b) If veteran, name war	3 (c) Social Security Account No.
Spanish American	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Grace Ramsay
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1880

8. AGE: Years	Months	Days	If less than one day
64	9	1	hr. min.

9. Birthplace Rossville, Ill. (Town, county, and state)
10. Usual Occupation Osteopath
11. Industry or business Self.

FATHER
12. Name Anderson McMains
13. Birthplace Indiana

MOTHER
14. Maiden Name Clarissa Comstock
15. Birthplace N. Y.

16 (a) Informant Dr. Grace R. McMains
(b) Address 4230 Loch Raven Blvd. 18

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 11 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1944, at 11 45 A.M.

21. I certify that I took charge of the remains described above, held an Inquisition thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Oct 11 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21504

462 010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

66b

Registered No. G21504

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Montgomery
(c) City or town Gaithersburg
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hargett

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-22-91

8. AGE: Years	Months	Days	If less than one day
53	6	18	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Johann Hargett
13. Birthplace Md.

MOTHER
14. Maiden Name Clara Reder
15. Birthplace Md

16 (a) Informant Rhonda
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10-12-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Silver Spring Md.

18 (a) Funeral director Warner & Pumphrey
(b) Address 8434 Georgia Ave Silver Spring

19 (a) Date received by local registrar OCT 12 1944 (b) Huntington Williamsport, Md.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1944, at 10.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7- 1944 to Oct 11 1944, and that I last saw him alive on Oct 11 1944.

Immediate cause of death (a) Carcinoma

Due to

Due to

Other Conditions (Over)
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
2 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 10/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write in spaces MARKED RESERVED FOR HEADING. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

221505

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

62

Registered No. G21505

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State N.Y. (b) County
(c) City or town Hammondsport (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Esther Payne
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Clarence
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 11-26-91
8. AGE: Years 52 Months 10 Days 15 If less than one day hr. min.
9. Birthplace N.Y. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Hiram Bennett
13. Birthplace N.Y.
MOTHER 14. Maiden Name Julia Tomer
15. Birthplace N.Y.
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 12 '44 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem. Location Frankfurt N.Y.
18 (a) Funeral director John O. Mitchell Sons Co.
(b) Address 1900 Eutaw Place
19. (Date received by local registrar) OCT 12 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944 at 5 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1944 to Oct 11 1944 and that I last saw her alive on Oct 11 1944

Immediate cause of death: Dimmons cachexia — Duration 2 yrs.
Due to: Infarction of pituitary
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide at M
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert A. Hatten
Address Johns Hopkins Hosp. Date signed 10/11/44

G21506

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192C

Registered No. G21506

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1336 James ST.
(c) Hospital or institution: 21

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1336 James St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ralph M Carver

3 (b) If veteran, name war

3 (c) Social Security Account No. 220-10-1332

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife Ruth Carver
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 20th 1910

8. AGE: Years	Months	Days	If less than one day
33 34	3	20	hr. min.

9. Birthplace Elkins W. Va. (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Bethlehem-Fairfield Co.

FATHER
12. Name Leslie Carver
13. Birthplace Unknown

MOTHER
14. Maiden Name Pearl Clayton
15. Birthplace W. Va.

16 (a) Informant Ruth Carver
(b) Address 1336 James St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 (a) OCT 12 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION 20

20. DATE OF DEATH October 11 1944, at 12 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the cause of death were:

IMMEDIATE CAUSE OF DEATH Chronic Rheumatic Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner
Date signed October 11 1944

G21507

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1222

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hosp 27

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 15 W. Hamilton and Rogers Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Kirk Morgan

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife: Mary E Morgan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9 - 10 - 1871

8. AGE: Years	Months	Days	If less than one day
73	1	0	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Retired - Inmate
11. Industry or business House for Aged

FATHER
12. Name (Unknown) Morgan
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Records Md Gen'l Hospital
(b) Address Howard & Madison Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/47 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Fayette St

19 (a) OCT 12 1947 (Date rec'd by Reg.) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1947, at 11:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-25 1947, to 10-10 1947 and that I last saw him alive on 10-10 1947.

Immediate cause of death Respiratory failure — Duration

Due to generalized debilitation — Duration

Due to senile cerebral obstruction — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. F. McCormack M. D.
Address Maryland General Hosp Date signed 10-11-47

G21508

JO #84897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G21508

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 mos. 23 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5215 Eleanor Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

28 - 1

3 (a) FULL NAME Mollie P. Hopkins

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife: William (d)
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug. 20, 1855
8. AGE: Years 89 | Months -1- | Days 19 | If less than one day hr. min.
9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Sheridan
13. Birthplace Maryland

MOTHER
14. Maiden Name Jane Morris
15. Birthplace Scotland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Presbyterian
Location Govans

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

OCT 12 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION P

20. DATE OF DEATH October 9, 1944, at 10:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 10, 1943 to Oct. 9, 1944, and that I last saw h. alive on Oct. 9, 1944

	Duration
Immediate cause of death: Bronchopneumonia	2 wks
Due to: Hypertensive Cardiovascular disease	?
Due to:	
Other Conditions: Gen. arteriosclerosis	?

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. Kenneth Smith M. D.
Address Balt. City Hosp. Date signed 10/11/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and legibly. Physicians: please write correct age is especially important.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21509

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G21509

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1022 S. Paca st
(c) Hospital or institution: 21 - 1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 S. Paca st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence N. Worley

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Male — 5. Color or race White — 6 (a) Single, married, ~~widowed, or~~ divorced. Married

6 (b) Name of ~~husband or~~ wife Amelia Worley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1st 1883

8. AGE: Years	Months	Days	If less than one day
61	3	8	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business Union Transfer Co.

FATHER
12. Name William Worley
13. Birthplace Pa.

MOTHER
14. Maiden Name Dora (Unknown)
15. Birthplace "

16 (a) Informant Amelia Worley
(b) Address 1022 S. Paca St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location A. A. Co. Md.

18 (a) Funeral director William Cook Dec'd
(b) Address 1217 St Paul St

OCT 12 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 9th 1944, at 2 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944, to Oct 9 1944 and that I last saw him alive on Oct 4 1944

Immediate cause of death	Duration
Due to Myocarditis	
Due to	
Other Conditions Influenza arthritis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Samuel Rubenstein M. D.
Address 203 Baltopass Ave Date signed

VS 150

G21510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G21510

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3915 Falls Road
(c) Hospital or institution: 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3915 Falls Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Rose Way Wilson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1904

8. AGE: Years 40 | Months 5 | Days 21 | If less than one day hr. min.

9. Birthplace Alder Virginia (Town, county, and state)

10. Usual Occupation Cashier
11. Industry or business H. L. Grant Co

FATHER
12. Name James Wilson
13. Birthplace Yorkshire, England

MOTHER
14. Maiden Name Sarah Green
15. Birthplace Catlett's Va

16 (a) Informant Margaret Braithewite
(b) Address Middletown Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13 1944 (month) (day) (year)
(c) Cemetery or crematory Middleburg Va
Location Middleburg Va

18 (a) Funeral director W. M. Cook Inc
(b) Address Baltimore Md

(c) Date rec'd by registrar OCT 12 1944 (d) Signature of Registrar Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11, 1944 at 6:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Oct. 11, 1944 and that I last saw h[illegible] alive on Oct. 5, 1944

Immediate cause of death Carcinoma of breast with metastases — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Victor L. Levy
Address 2322 Eastern Pkwy Date signed 10/11/44

G21511

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G21511

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 Fell St
(c) Hospital or institution: 2-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 901 Fell St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME David Schloss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
White	White	Widower

6 (b) Name of husband or wife Late Sari

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years	Months	Days	If less than one day
58			hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Merchant

FATHER
12. Name Abraham Schloss
13. Birthplace Russia

MOTHER
14. Maiden Name Sophia Gluchofsky
15. Birthplace Russia

16 (a) Informant Toney Schloss
(b) Address 2414 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) OCT 12 1944 (b) [illegible] Burial M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1944, at 10:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1 1 1943 to 9/6 1944 and that I last saw h[illegible] alive on 9/9 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M Shadeck M. D.
Address 1226 Linden Ave Date signed 9/10/45

G21512

JO #90178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21512

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 Madison Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: Mary Goode

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Jesse

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1897

8. AGE: Years 46 | Months 10 | Days 22 | If less than one day hr. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name: William H. Bruce
13. Birthplace: " Howard Co., Md. "

MOTHER — 14. Maiden Name: Susie Smith "
15. Birthplace: Howard Co. Md. "

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)
(c) Cemetery or crematory: St. Louis Cem.
Location: Clarksville, Md.

18 (a) Funeral director: Easton Sons
(b) Address: Ellicott City, Md.

(c) Date received: OCT 12 1944 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1944, at 9:46AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10, 1944 to Oct. 11, 1944, and that I last saw her alive on Oct. 11, 1944.

Immediate cause of death: Sepsis Peritonitis — Duration: 1 day

Due to: Pelvic Abscess with rupture — Duration: 7 days

Other Conditions: Fibroid

(Include pregnancy within 3 months of death)

Date of operation: None

Major findings of operation:

of autopsy: Above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: R. M. Cunningham M. D.

Address: Balto. City Hosp. Date signed 10-11-44

C21513

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830a

Registered No. C21513

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4420 Falls Rd.
(c) Hospital or institution: 27-15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4420 Falls Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JONAS MARKOWITZ

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Dena
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1858

8. AGE: Years	Months	Days	If less than one day
86			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Israel
13. Birthplace Russia
14. Maiden Name Blaustein
15. Birthplace Russia

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)
(c) Cemetery or crematory Bonsdale
Location Pikesville Rd. & Hamilton Ave.

18 (a) Funeral director Jack Levin Inc.
(b) Address 1439 E. Balto St.

19 (a) OCT 12 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1944, at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Oct 11 1944, and that I last saw h[im] alive on Oct 11 1944.

Immediate cause of death: a Cer. Arterio sclerosis — Duration: 1 day
Due to Arterial Hemorrhage
Due to arter. sclerosis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature S. C Feldman
Address 1440 E Balto St Date signed 10/11/44 (M. D.)

G21514

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G21514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument st & Rutland Ave
(c) Hospital or institution: Sinai Hosp. 13

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2404 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Finkelstein

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife Sarah -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER	12. Name Jacob Finkelstein
	13. Birthplace Russia
MOTHER	14. Maiden Name Rose -
	15. Birthplace Russia

16 (a) Informant Mrs Edw. Rosenau
(b) Address 3705 Chatham Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Memorial Park
Location

18 (a) Funeral director Jos Levin Sons
(b) Address 1439 E Balto St

19 (a) OCT 12 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 1944 at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 8 1944 to Oct 11 1944 and that I last saw h[illegible] alive on Oct 11 1944.

Immediate cause of death	Duration
cardio-respiratory failure.	
Due to circulatory accident	
Due to cerebro-sclerosis and hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: above findings not confirmed - not fully determined.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Tucker M.D. M. D.
Address Sinai Hosp. Date signed 10/12/44

G21515

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 124a

G21515 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2137 Harford Road
(c) Hospital or institution: 8-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2137 Harford Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert V. Michael

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-1663

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Estella Michael
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 9, 1883

8. AGE: Years	Months	Days	If less than one day
61	93	1	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Tapman
11. Industry or business Gunther Brewry Co

FATHER
12. Name Wm. Michael
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary Lewis
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Estella Michael
(b) Address 2137 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13/44 (month) (day) (year)
(c) Cemetery or crematory London Park Cem.
Location Balto. Md.

18 (a) Funeral director Philip Herwig Sons
(b) Address 2024 Orleans St.

19 OCT 12 1944 Registrar for Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10/44 19 , at 7 AM

21. I certify that death occurred on the date above stated; that I attended deceased from April 1944 to Oct. 10 1944, and that I last saw h[illegible] alive on Oct. 9 1944

Immediate cause of death Uremia — Duration 2 wks

Due to Sclerosis of prostate — years

Due to Nephritis — 2 yrs

Other Conditions Alcohol

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Fred J. Zimmerman M. D.
Address 2858 Harford Date signed 10/11/44

VS 180

G21516

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G21516 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1724 Eutaw Place
(c) Hospital or institution: ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1724 Eutaw Place (If rural give location)
(e) Citizen of foreign country? ✓ (Yes or No)
If yes, name country ✓

3 (a) FULL NAME Gustave B. Webb

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Dudley R. Webb

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Dec 29. 1866

8. AGE: Years 77 | Months 9 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation ✓

11. Industry or business ✓

FATHER
12. Name Daniel McCann
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary Biddle
15. Birthplace Wilmington, Del.

16 (a) Informant Dudley R. Webb
(b) Address 4920 Elkins, Philada. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Balto. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 OCT 12 1944 (b) Thursday for Mitchell (Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/ 1944, at 3:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941, to 10/10 1944, and that I last saw her alive on 10/10 1944.

Immediate cause of death: Cardiac Insufficiency — Duration 3 years

Due to: General Arteriosclerosis, Cardiac Hypertrophy

Due to: Hypertension

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____ (Specify type of place)
(e) Means of injury ____

23. Signature Theodore Cooper M. D.
Address 2107 Park Ave Date signed 10/10/44

G21517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 877

Registered No. G21517

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2926 N. Calvert street
(c) Hospital or institution: 12-2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 N. Calvert street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME ELLEN O'NEILL

3 (b) If veteran, name war: ---
3 (c) Social Security Account No. ----

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Patrick O'Neill
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Mar. 17, 1876
8. AGE: Years 68 | Months 6 | Days 24 | If less than one day hr. min.
9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name John Moore
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Manning
15. Birthplace Ireland

16 (a) Informant Mr. Patrick O'Neill
(b) Address 2926 N. Calvert street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas J. Evans Son Inc
(b) Address 118 N. Mt. Royal Ave

19 OCT 12 19[illegible] (Date received by registrar) [illegible] for William A. [illegible], Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1943 to Oct 11 1944 and that I last saw her alive on Apr 19 44

Immediate cause of death	Duration
Hypernephroma	2 yrs
Due to Cardiac Sclerosis	
Due to	
Other Conditions Cerebral Sclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H N Pearce M. D.
Address 2105 Eutaw st Date signed 10/12/44

approved by Homer J. Mullen, M.D. 10/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21518

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G21518

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2705 The Alameda
(c) Hospital or institution:
9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ---
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2705 The Alameda
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HOWARD L. MACCUBBIN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sadie B. Gross

6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 19, 1878

8. AGE: Years 66 | Months 4 | Days 22 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Charles.Maccubbin
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Cora Palmer
15. Birthplace Maryland

16 (a) Informant Mrs. Sadie Gross Maccubbin
(b) Address 2705 The Alameda

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location

18 (a) Funeral Director Chas. J. Evans Son Inc.
(b) Address 118 W. Mt. Royal Ave.

(Date received by Registrar) OCT 12 1944

(b) Huntington Williams M.D. Registrar

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1943, to Oct 11 1944, and that I last saw ~~he~~ alive on Oct 11 1944

Immediate cause of death Coronary Thrombosis — Duration 5 days

Due to Myocarditis — 2 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

Signature Fred L. Zimmerman M. D.

Address 9858 Harford Rd Date signed 10/12/44

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21519

70-289869

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21519 Registered No. 1316

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals 22-2

(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 da.

(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 512 N. Conway St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Harvey Hilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Anna Hilton

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1892

8. AGE: Years	Months	Days	If less than one day
51 52	11 10	24 25	hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER

12. Name General Hilton (d)

13. Birthplace South Carolina

MOTHER

14. Maiden Name Ella Johnson (d)

15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/12/44 (month) (day) (year)

(c) Cemetery or crematory Manning

Location S.C.

18 (a) Funeral director Daniel G. Brown & Son

(b) Address 1624 Montgomery St

19 OCT 12 1944 (Date rec'd by registrar) (b) Harrington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1944, at 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19, 1944 to Oct. 10, 1944 and that I last saw h im alive on Oct. 10, 1944.

Immediate cause of death	Duration
Bronchopneumonia	6 days
Due to Uremia Coma	2 weeks
Due to Chronic glomerular nephritis	?
Other Conditions Hypertensive cardio vascular disease	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature N M. Phillips M. D.

Address Balt. City Hospitals Date signed 10-11-44

VS 150

G21620

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G21520

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 700 W. 40th St
(c) Hospital or institution:
The Home for Incurables
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Yrs
(e) Length of stay in Baltimore (yrs., mos., or days) 15 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town ~~Annapolis~~ Eastport
(If outside city or town limits, write RURAL and give town)
(d) Street No. 209 Severn Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Susie Elizabeth Mitchell

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Walter E. Mitchell

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) 12 - 31 - 1875

8. AGE: Years 71 | Months 10 | Days 11 | If less than one day ____ hr. ____ min.

9. Birthplace Annapolis, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business —

FATHER
12. Name Williams Pinkie
13. Birthplace ~~Maryland~~ Philadelphia, Pa

MOTHER
14. Maiden Name Margaret Woods
15. Birthplace Calvert Co. Md

16 (a) Informant Mrs. Elmer Pregar
(b) Address 209 Severn Ave. Eastport, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1944 (month) (day) (year)

(c) Cemetery or crematory Cedar Bluff Cemetery
Location Annapolis, Md.

18 (a) Funeral director Willis Lamborn
(b) Address 1005 W. Baltimore St.

OCT 12 1944 (Date rec'd by registrar) (b) Burlington for Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944, at 1:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/14 1929 to 10/11 1944, and that I last saw h.e alive on 10/11 1944.

Immediate cause of death	Duration
Cerebrovascular Hemorrhage	6 hrs
Rheumatoid Arthritis	28 yrs
Due to	
Due to	
Other Conditions Bedsores Colorado	15 yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Grafton Thompson M. D.
Address 24 Medical Arts Bldg Date signed 10/14/44

G21521

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G21521

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Lexington St.
(c) Hospital or institution: Aged Women & Aged Men's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 y
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 W. Lexington St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3. (a) FULL NAME Catherine Elizabeth Snyder

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Daniel Webster Snyder
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5 1862

8. AGE: Years 84 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Geo. W. Peppenberger
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine (unknown)
15. Birthplace Germany

16 (a) Informant Mrs Gladys Dean (Granddaughter) DeNoe
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Rd.

18 (a) Funeral director John R Kemmerer
(b) Address 1212 Linden Ave., Baltimore MD

19 (a) (Date received by registrar) OCT 12 1944 (b) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/10/44 19 at 6:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1/29/1936 to 10/10/44 19, and that I last saw her alive on 10/9/44 19.

Immediate cause of death: Cardio-vascular renal disease. Hypertension. — Duration: ? yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edward B Smith M.D.
Address 11 E. Chase St., City. Date signed 10/12/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G21522

JO #89377

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21522

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 28 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1009 N. Saratoga St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Thelma Rawls

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1920

8. AGE: Years 24 | Months -1- | Days 16 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Robert Rawls
13. Birthplace Maryland

MOTHER
14. Maiden Name Ellen Scott
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

19 (a) (b) Huntington Williams, M.D.
OCT 13 1944

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1944 at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 12, 1944 to Oct. 10, 1944, and that I last saw her alive on Oct. 10, 1944.

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 10/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

461 705

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55L

Registration No. 324523

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1501 W. Rawlins St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lloyd Booker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced.
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-29-30
8. AGE: Years 13 | Months 9 | Days 12 | If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Lloyd Booker
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Strother
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St.

OCT 13 1944
Date Received by Local Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 10 1944 at 6.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-1 1944 to Oct-10 1944, and that I last saw him alive on Oct-10 1944

Immediate cause of death: Respiratory failure — Duration
Due to: Lymphosarcoma with widespread metastases
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation April 1944
Major findings of operation: Lymphosarcoma
of autopsy Lymphosarcoma

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 10/11/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21524

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21524 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 E Monument
(c) Hospital or institution Saints Josephs
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 - 2
(e) Length of stay in Baltimore (yrs., mos., or days) 52 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and the town)
(d) Street No. 2701 E. Monument St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Henry Frank

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-01-1558

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary Agnes

6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Feb 6 - 1892

8. AGE: Years	Months	Days	If less than one day
52	8	5	hr. min.

9. Birthplace Balto Md. (Town, county and state)

10. Usual Occupation Foreman - Cantor

11. Industry or business Lumber Co.

FATHER
12. Name Joseph Franks
13. Birthplace Balto Md

MOTHER
14. Maiden Name Margaret Holzheid
15. Birthplace Balto Md

16 (a) Informant Mary Agnes Franks
(b) Address 2701 E Monument St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 44 (month) (day) (year)
(c) Cemetery or crematory Maryland Memorial
Location Balto Md

18 (a) Funeral director John C. Miller Inc.
(b) Address 2438 E. Oliver St.

OCT 13 1944 (Date received) Huntington Williams Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1944, at 3 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to Oct 11 1944 and that I last saw h.i.M alive on Oct 11 1944

Immediate cause of death Coronary thrombosis
Due to a congestive heart failure

	Duration
Due to	
Due to	
Other Conditions Uremia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph's Hospital Date signed 10-11-44

G21525 21525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

8 3 B

Registered No. G21525

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2439 St. Paul St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2439 St. Paul St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME ANNA ELIZABETH LURSSEN

3 (b) If veteran, name war --

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George F. Lurssen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1879

8. AGE: Years	Months	Days	If less than one day
65	1	8 7	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Karl Lange
13. Birthplace Germany

MOTHER
14. Maiden Name Gertrude Hiege
15. Birthplace Germany

16 (a) Informant Mr. George F. Lurssen
(b) Address 2439 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 13 1944 (Date received by registrar) Huntington Williams M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1944, at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 11 1943, to 10/10/1944, and that I last saw her alive on 10/10 1944.

Immediate cause of death Cerebral thrombosis — Duration 6 mos.

Due to

Due to

Other Conditions none

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm B Seale M. D.
Address 520 Med Arts Bldg. Date signed 10/14/44

G21526 21526 Lingle

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G21526

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as fully as possible. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St.
(c) Hospital or institution: Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Sept 27-44
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3026 Harford Rd (If rural give location)
(e) Citizen of foreign country? (Yes) (No) If yes, name country No.

3 (a) FULL NAME Miss Dora Louise Lingle

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: No Husband
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 27-1897

8. AGE: Years 47 | Months 0 | Days 14 | If less than one day hr. min.

9. Birthplace Rowan Co. North Carolina (Town, county, and state)
10. Usual Occupation Church Secretary
11. Industry or business Christ Eng. Lu. Church

FATHER
12. Name Littleton W. Lingle
13. Birthplace N. C

MOTHER
14. Maiden Name Margaret Bost
15. Birthplace N. C

16 (a) Informant Mrs. Wm Markert
(b) Address 3026 Harford Rd.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Location Salisbury, North Carolina

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto. Md

(c) Filed OCT 13 1944 (Date filed) Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 11 1944, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 10 1944, and that I last saw her alive on Oct 10 1944.

Immediate cause of death: Carcinomas of Cervix with Metastasis to
Due to: Peritoneum with
Due to: Ascites Abdomen
Other Conditions:

Duration in Mos. to from Sept 29 1944 to 10-11-44

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Univ. Hospital Date signed 10/14/44

D-21527.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

D 21527

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 Calvert
(c) Hospital or institution:
Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 57 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Bretton Place City
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Juliet W. Reese (Juliet Wilson Reese)

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Guy H. Reese

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Nov-27-1887

8. AGE: Years 56 Months 10 Days 14 If less-than-one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Edward C. Wilson (dead)
13. Birthplace Virginia

MOTHER
14. Maiden Name Anna K. Carter
15. Birthplace Virginia

16 (a) Informant Mr. L.C. Wilson (brother)
(b) Address 1324 Crofton Rd., Baltimore

17 (a) Cremation (b) Date thereof 10-13-44
(Burial, cremation, removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(W. F. MOWEN SUC.) 106 W. MOUNT AVENUE
(b) Address

19 (a) (b)

OCT 13 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1944, to October 11 1944, and that I last saw her alive on October 11 1944

Immediate cause of death Cardio-respiratory failure — Duration

Due to Carcinoma of Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Stephen J. Von Lilla M. D.
Address Union Memorial Hosp. Date signed 10-11-44

G21528 S-21528

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G21528

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be answered. Cancellations or alterations must be explained. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 E Fort ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 E Fort ave (If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME John P. Daugherty

3 (b) If veteran, name war: no
3 (c) Social Security Account No. 214-16-9058

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife ✓
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 29 1919

8. AGE: Years	Months	Days	If less than one day
25	1	11	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business Wm Hoare Lead Drayton

FATHER
12. Name John P Daugherty
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret McHale
15. Birthplace Ireland

16 (a) Informant John P. Daugherty (Father)
(b) Address 1511 E Fort Ave

17 (a) Burial. (b) Date thereof 10/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Old Frederick Rd.

18 (a) Funeral director Chas. F. Dill.
(b) Address 1507 E. Fort Ave.

19 (a) (b) Huntington Williams M.D.
(Signature of Registrar)

OCT 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1944, at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944 to Oct 9 1944, and that I last saw h[e] alive on Oct 9 1944

Immediate cause of death	Duration
Mitral Regurgitation	37
Secondary	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T Ga Stearns M. D.
Address 2828 Harford Ave Date signed 10 10 44

G21529 21529 BALTIMORE CITY HEALTH DEPARTMENT X ✓ G21529

Registered No.

CERTIFICATE OF DEATH 83a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St Agnes Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Hakethorpe
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4606 Linden ave (23)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Cagle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Laura

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 13, 1894

8. AGE: Years 50 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B & O

FATHER 12. Name R. Morris Cagle

13. Birthplace Md.

MOTHER 14. Maiden Name Ella Gorsuch

15. Birthplace Md.

16 (a) Informant Wife

(b) Address Same add

17 (a) Burial (b) Date thereof 10 14 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Calvary

Location Gamber (md.)

18 (a) Funeral director J. F. Reese

(b) Address Westminster Md

19 (a) (b) Huntington Williams, W. V.
(Name and address of registrar)

OCT 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12- 1944, at 9:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11-44 19 to 10-12- 1944, and that I last saw him alive on 10-12 19 44

Immediate cause of death Respiratory Failure

Due to Central Hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Routzahn M. D.

Address St. Agnes Hosp Date signed 10-12

G21530

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 102

Registered No. G21530

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St Agnes' Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 5 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Jenkins Memorial Hosp. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Father James Joseph Egan
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace Md. (town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name James Egan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary J. Moran
15. Birthplace Ireland.

16 (a) Informant Fr. Edmund
(b) Address St. Agnes' Hospital

17 (a) Burial (b) Date thereof 10/14/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Catholic Cem
Location

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 2054 E. 22nd St

19 (a) OCT 13 1944 (b)
(Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1944 to 10-11 1944 and that I last saw him alive on 10-11 1944.

Immediate cause of death Cardiac Failure — Duration
Due to Malignant Essential Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jos A. Devany M. D.
Address St Agnes Date signed 11-1 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C21531

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. C21531

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1345 S Charles St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 2 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1345 S. Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Otto A. Schaub

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mollie Schaub
6 (c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.) Dec 07, 1871

8. AGE: Years 72 | Months 9 | Days 14 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William Schaub
13. Birthplace Germany

MOTHER
14. Maiden Name Jennie Krapp
15. Birthplace Balto. Md

16 (a) Informant Mollie Schaub
(b) Address 1345 S. Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City
18 (a) Funeral director J. Howard Evans
(b) Address 1400 S. Charles St

19 (a) (Registrar) (b) Huntington Williams M.D.

OCT 13 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11, 1944, at 6:30a M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 8 1943 to 10/11/44, and that I last saw him alive on 10/11/44.

Immediate cause of death: Hypertensive cardio vascular renal disease — Duration: 1 year

Due to —

Due to —

Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Deibel M.D.
Address 1226 Hanover St. Date signed 10/11 1944.

G21532 ✓ G21532

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 12B

Registered No.

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution:
Church Home 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Maryland~~ (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1118 Homestead ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME David Schwartz

3 (b) If veteran, ~~World~~ war ~~#~~ Merchant Marine | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Cecelia Schwartz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1890

8. AGE: Years	Months	Days	If less than one day
54	3	26	hr. min.

9. Birthplace Florida
(Town, county, and state)
10. Usual Occupation Engineer (Supervising)
11. Industry or business Capital Power House

FATHER
12. Name David Schwartz
13. Birthplace New York

MOTHER
14. Maiden Name Katherine Porter
15. Birthplace Florida

16 (a) Informant Cecelia Schwartz
(b) Address 1118 Homestead st

17 (a) Burial (b) Date thereof 10/13/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~or crematory~~ Moreland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul st.

19 (Filed) OCT 13 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-12 1944, at 1 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-8 1944, to 10-12 1944, and that I last saw him alive on 10-12 1944.

Immediate cause of death atelectasis
left lung and acute
cardiac failure — Duration 3 hrs

Due to asthma — 2 yrs

Due to (2) pulmonary tuberculosis
with (1) bronchial stenosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations —

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marion H. Davis M. D.
Address Church Home Date signed 10-12-44

G21533 LeimKuhler ✕ ✓ G21533

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: Anne Arundel
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. Severna Park Md (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elanor Leimkuhler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Frank Leimkuhler

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-6-1[illegible]

8. AGE: Years 26 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation H.W.

11. Industry or business

FATHER
12. Name Charles Downes
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Bauer
15. Birthplace Balto. Md.

16 (a) Informant Frank Leimkuhler
(b) Address Severna Pk. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 12/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cem.
Location Eastern Ave.

18 (a) Funeral director John A. Miller
(b) Address 2334 Jefferson St.

OCT 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-9 1944, at 8 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1944 to 10-9 1944 and that I last saw h[illegible] alive on 10-9 1944

Immediate cause of death Uremia — Duration

Due to Hypertensive Cardio-Vascular Renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.E. Robertson M.D.
Address St. Joseph's Hosp. Date signed 10-[illegible]-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G21534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

11 7a

G21534 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address St. Agnes Hosp.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 6400 Charles St. Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles Govatsos

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W | 6 (a) Single, married, widowed or divorced: W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15, 1874

8. AGE: Years 70 | Months 7 | Days 25/26 | If less than one day hr. min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Nicholas Govatsos
13. Birthplace Sparta, Greece

MOTHER 14. Maiden Name Angeliki Lazarakis
15. Birthplace Sparta Grece

16 (a) Informant Son: Dr. George Govatos
(b) Address 6400 Charles St. Ave

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)

(c) Cemetery or crematory
Location Woburn, Mass.

18 (a) Funeral director J. Francis Reese
(b) Address Westminster, Md.

19 (a) (b)

OCT 13 1944

VS 150

Hunting for Baltimore, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11- 1944 at 9:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6- 1944 to 10-11- 1944 and that I last saw him alive on 10-11- 1944.

Immediate cause of death	Duration
Circulatory Collapse	
Due to Acute hemorrhage	
Due to Bleeding Peptic ulcer	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jose A. Alvarez M. D.
Address St. Agnes Hospital Date signed 10-11-44

G21535

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G21535
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Myrtle Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

N-2

3 (a) FULL NAME Elizabeth K. White
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Deceased
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/85

8. AGE: Years 59 | Months 7 | Days 4 | If less than one day hr. min. 18 16

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Kennard
13. Birthplace Md

MOTHER
14. Maiden Name Jane Wright
15. Birthplace Md

16 (a) Informant Mrs. Jane Timmons
(b) Address 922 Upper St. Phila. Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Balto. Co., Md.

18 (a) Funeral director Mr. Frances H. Stansbury
(b) Address 578 W. Fayette St.

19 (a) (Date rec'd by registrar) OCT 13 1944 (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1944, at 7:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2 1944 to Oct. 9 1944, and that I last saw her alive on Oct. 9 1944.

Immediate cause of death: Thoraco abdominal injuries of a traumatic nature — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident.
(b) Date of occurrence October 2, 1944 at P. M.
(c) Where did injury occur? 1213 Myrtle Avenue (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. (Specify type of place) While at work? Housework
(e) Means of injury: Slipped and fell on floor.

23. Signature [illegible] M.D.
Address St. Joseph's Hosp. Date signed 10/10/44

N-2 Wallenweber MN Antithrombin Pranka

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21536 — BALTIMORE CITY HEALTH DEPARTMENT — G21536

CERTIFICATE OF DEATH

8 3 D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3814 White Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 6 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3814 White Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kate Augusta Seitz

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Fe	Wh	W

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 1857

8. AGE: Years	Months	Days	If less than one day
86	9	;6	hr. min.

9. Birthplace Baltimore City (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home

FATHER
12. Name John C. Evans
13. Birthplace Loch Raven, Balto. Co.

MOTHER
14. Maiden Name Ellen Brown
15. Birthplace Baltimore City

16 (a) Informant Mrs. Everett Steffox
(b) Address 3814 White Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Park, Balto.
Location Towson

18 (a) Funeral director Lassahn Fullerton Home
(b) Address 7401 Belair Rd

19 (a) (Date rec'd by Reg.) Sat 14 Registrar
OCT 13 1944
Verified Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11- 1944, at 11.15 p.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 15 1939, to Oct 11 1944, and that I last saw her alive on 10-11- 1944.

	Duration
Immediate cause of death: Cardiac insufficiency	5 das
Due to: Left Hemplegia from	1939
Due to: Arteriosclerosis	Yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 10-11-

G21537

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21537 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2249 E Chase St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 4
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2249 E Chase St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William W. Rabenau

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-05-8914

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Catherine M.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 8-1879

8. AGE: Years 64 | Months 11 | Days 1 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Dyer

11. Industry or business Cleaning & Dyeing

FATHER
12. Name John Rabenau
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Behring
15. Birthplace Germany

16 (a) Informant Mrs Catherine M. Rabenau
(b) Address 2249 E. Chase St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-12-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director Kendall E Hunt Sons
(b) Address No 1 W. Madison

19 (a) (Date rec'd by registrar) (b) Registrar

VS 180 OCT 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 1944 at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944 to Oct 1944 and that I last saw h— alive on Oct 9 1944.

Immediate cause of death: Coronary Thrombosis — Duration 10/9/1944

Due to: Ch. Myocard. D.

Due to: Hypertension Cardio-Vascular disease — 1944

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Rogers M.D.
Address 801 N Kenwood Ave Date signed 10/12/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

21538

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

Registered No. G21538

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2833 Mayfield Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town paltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2833 mayfield Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE THOMAS CLARKE

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Katherine M. Clarke
6 (c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): May 28, 1871

8. AGE: Years: 73 | Months: 4 | Days: 12 | If less than one day: hr. min.

9. Birthplace: Queen Ann Co. Va (Town, county, and state)

10. Usual Occupation: retired yard Master (8

11. Industry or business: B & O R.R

FATHER
12. Name: George Clarke
13. Birthplace: Meherrin, Va. Prince Edward Co

MOTHER
14. Maiden Name: Mary Pollard
15. Birthplace: Meherrin, Va

16 (a) Informant: Mrs. Katherine M. Clarke
(b) Address: 2833 Mayfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-13-44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Avenue & Broadway

19 (a) OCT 13 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10, 1944 at 12.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from oct. 9 1944 to oct 10 1944.
and that I last saw h/m alive on oct 10 1944.

Immediate cause of death: atrophic Cirrhosis of liver

Due to:

Due to: yrs)

Other Conditions: Varices of Oesophagus + Stomach (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter a Anderson M. D.
Address 3001 Shannon Drive Date signed Oct. 11-44

VS 180

G21539 ✓ G21539

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3104 Royston Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3104 Royston Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER SCOTT RUSSELL

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Helen Marie Lambdin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 19, 1874

8. AGE: Years	Months	Days	If less than one day
70	2	22	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Painter
11. Industry or business Retired 11 yrs.

FATHER
12. Name Joseph Alexander Russel
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Elizabeth Elliott
15. Birthplace Maryland

16 (a) Informant Mrs. Helen M. Russell
(b) Address 3104 Royston Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 (a) OCT 13 1944 Hunting for Williams, M.D.
(Date received by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 11 19 44, at 10.10 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 19 44, to Oct. 11 19 44, and that I last saw h alive on Oct. 10 19 44

Immediate cause of death	Duration
Cerebral Apoplexy	Fourhs,
Due to Hypertension - arterio sclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm McCamly M. D.
Address 701 N. Kenwood Ave. Date signed 10/11/44

G21540

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G21540

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1905 Christian St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1905 Christian St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patricia L. Collins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 7, 1944

8. AGE: Years X | Months 1 | Days 7 | If less than one day ___ hr. ___ min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James E. Collins
13. Birthplace Md

MOTHER
14. Maiden Name Ruth Stricker
15. Birthplace Md.

16 (a) Informant James E. Collins
(b) Address 1905 Christian St

17 (a) Burial (b) Date thereof 10-17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location 3100 Old Frederick Rd

18 (a) Funeral director Harry A. Wilke
(b) Address 1016 Arlington Ave.

19 (a) OCT 13 1944 Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1944, at 9 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944, to Oct 11, 1944, and that I last saw her alive on Oct 11, 1944.

Immediate cause of death: Acute Heart Disease — Duration: 5 wks

Due to:

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the causes to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul A. Campbell M. D.
Address 300 E. Lanvale St Date signed 10 11 1944

G21541 3 ✓ G21541

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 639 Calhoun Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Franck Travers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	W

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 14 - 1885

8. AGE: Years	Months	Days	If less than one day
59	5	27	hr. min.

9. Birthplace Balto - Md
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Max Wagner
13. Birthplace Md

MOTHER
14. Maiden Name (Ella Wagner)
15. Birthplace Md

16 (a) Informant Mr Harry H. Franke
(b) Address 504 North Bend Rd

17 (a) Burial (b) Date thereof 10-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Wittke
(b) Address 4101 Edmondson Ave.
(c) OCT 13 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-11 1944, at 12:29 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944 to 10/11 1944 and that I last saw h.e alive on 10/11 1944

Immediate cause of death
Pulmonary Embolism — Duration 1 da
Due to
Due to Repair of Post operative Hernia
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation 10/4/44
Major findings of operation: Repair of Post Operative Hernia
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Joseph G Lawrence M.D.
Address 670 Washington Blvd Date signed 10/13/44

G21542 45804 1

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G21542 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1216 Harford Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gertrude L Harris
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Paul —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-6-25

8. AGE: Years 19 | Months 3 | Days 6 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Ernest Harris
13. Birthplace Va.

MOTHER
14. Maiden Name Susie Jones
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 14/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto Md

18 (a) Funeral director Mrs Albert A Elliott & Dgt
(b) Address 1129 N. Caroline St.

19 (a) (Date received by local registrar) (b) OCT 13 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1944 at 9a M 49

21. I certify that death occurred on the date above stated; that I attended deceased from July 24 1944 to Oct 12 1944 and that I last saw him alive on Oct. 12 1944

Immediate cause of death: Pulmonary Tuberculosis Far advanced — Duration yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp Date signed 10/12/44

G21543 BALTIMORE CITY HEALTH DEPARTMENT G21543
CERTIFICATE OF DEATH 52 R Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 751 CARROLL. ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 751 CARROLL ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE M. HIRSCH.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex FEM | 5. Color or race WHITE | 6 (a) Single, married, widowed, or divorced. WIDOW

6 (b) Name of husband or wife JOHN HIRSCH.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 17--1869

8. AGE: Years 75 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business —

FATHER
12. Name GEORGE KNELL
13. Birthplace BALTO - MD.

MOTHER
14. Maiden Name MARY. BOOKER.
15. Birthplace NOT KNOWN

16 (a) Informant EDW. HIRSCH.
(b) Address 751 CARROLL ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Oct. 14-44 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto Md.

18 (a) Funeral director Bernard C. Hall
(b) Address 121 E West St

19 (a) (Date received) OCT 13 1944 by (Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944, at 5A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1st 1943 to Oct 11 1944 and that I last saw h[er] alive on Oct 18th 1944

Immediate cause of death (primary) Carcinoma of bladder — Duration 1 year

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Harry Heath M. D.
Address 517 Scott St Date signed 10/12/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21544

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G21544 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2235 Pennsylvania Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2235 Pennsylvania Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Creel

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed or divorced: Widowed

6 (b) Name of husband or wife Hilliard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16, 1896

8. AGE: Years 47 | Months 3 | Days 20 | If less than one day hr. min.

9. Birthplace Bowman, S.C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Alfred Kelly
13. Birthplace Bowman, S.C.

MOTHER 14. Maiden Name Mary Walker
15. Birthplace Bowman, S.C.

16 (a) Informant Margaret White
(b) Address 2007 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13, 1944 (month) (day) (year)
(c) Cemetery or crematory Gibeta Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Mrs. Lawr. H. Holland
(b) Address 631 Druid Hill Ave.

10 13 1944 (Date received by registrar) Huntington Williams, M.D.

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MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 8 1944, at 9:00a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944 to Oct 8 1944, and that I last saw h[illegible] alive on Oct 7 1944.

Immediate cause of death (a) Coronary Thrombosis — Duration

Due to Cardiac decompensation

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1543 Pennsline Date signed 10-13-44

G21545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G21545 Registered No. 171a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 710 Home (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William J. Sturdevant (Stursdevant?)

3 (b) If veteran, name war: Unknown

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day hr. min.

9. Birthplace Indiana (Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Balto Transit Co
(b) Address Balto

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Mendel Co Indiana
Location

18 (a) Funeral director Robert L Brooks
(b) Address 1338 Hollins St

19 (a) OCT 13 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 7, 1944 at 4 A M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-6-44 5-5 PM 4/2
(b) Where did injury occur? Fayette St, 25' east of Pine
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? Yes
(d) Means of injury struck by streetcar

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed 10-7-44

VS 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21546 ✓ G21546

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3400 Olympia Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3400 Olympia Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: EVELYN ROBERTS RICHARDSON

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert Richardson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 4, 1878

8. AGE: Years 66 | Months 3 | Days 8 | If less than one day hr. min.

9. Birthplace: Caswell Co., N. C. (Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: John M. Roberts
13. Birthplace: N. C.

MOTHER
14. Maiden Name: ~ Moore
15. Birthplace: N. C.

16 (a) Informant: Mrs. Robert Richardson
(b) Address: 20 Seven Mile Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Registered by registrar) (b)

OCT 13 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1944, at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20th 1938, to Oct. 12th 1944, and that I last saw h[illegible] alive on Oct 11th 1944.

Immediate cause of death: Chronic Myocarditis — Duration: 1 yr.
Due to: Coronary Sclerosis — 17 yr.
Due to: Art. Sclerosis — 2 yrs.
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: James A. Miller M.D.
Address: Pikesville-8, Md. Date signed 10/13/44

G21547 ✓ G21547

G21547

BALTIMORE CITY HEALTH DEPARTMENT 8/a Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dudeland St.
(c) Hospital or institution West Belts. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Harmans
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Mae Griffith

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife: Robert W. Griffith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 28, 1877

8. AGE: Years	Months	Days	If less than one day
67	3	13	hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Leonard Boyer
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Martha A. Garey
15. Birthplace A. A. Co., Md.

16 (a) Informant Mrs. Aind. Barr
(b) Address Harmans, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Friendship Cem.
Location Friendship, A. A. Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) OCT 13 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 19 44, at 11:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 19 44, to 10/11 19 44, and that I last saw h[illegible] alive on 10/4 19 44

Immediate cause of death	Duration
Pneumococcal Meningitis	1 week
Due to Pneumonia ?	2 wk.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M.D.
Address W.B.G.H. Date signed 10/14/44

G21548

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G21548 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 12

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County A.A.
(c) City or town Greenland Beach
(If outside city or town limits write RURAL and give town)
(d) ~~Street No.~~ Curtis Bay P.O.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) **FULL NAME** Ronald Michael Bartocci

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race wh | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1, 1944

8. AGE: Years | Months | Days 15 | If less than one day 1 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name albert Bartocci
13. Birthplace Newark New Jersey

MOTHER 14. Maiden Name Norma Cogbill
15. Birthplace Baltimore Maryland

16 (a) Informant Ruth Cockill
(b) Address Greenland Beach P.O. Curtis Bay

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1944, at 2.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 12 1944, and that I last saw h. alive on Oct 12 1944.

Immediate cause of death prematurity — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature F. D. Lawrence M.D.
Address Date signed

G21549

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G21549
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 3 10
(e) Length of stay in Baltimore (yrs., mos., or days) unknown

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Md
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St Baltimore
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amanda Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband ~~or wife~~ John Waters
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 1873

8. AGE: Years	Months	Days	If less than one day
71	9		hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Philip Elbert
13. Birthplace USA

MOTHER
14. Maiden Name Mary Jones
15. Birthplace U.S.A.

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Winefield
(b) Address 914 Greenmount Ave

19 (a) [illegible] Williams M.D.

OCT 13 1944 Huntington
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1944 at 8 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Oct 12 1944 and that I last saw ~~her~~ alive on 19

Immediate cause of death General Tuberculosis — Duration

Due to Myocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ottolt Dukes
Address 928 E. Northern Pkwy Date signed 10/13/44

G21550

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G21550

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D O A Johns Hopkins Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 S. Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen Joseph Sporny

3 (b) If veteran, name war: No

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 12 1900

8. AGE: Years 43 ~~44~~ | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER 12. Name Martin Sporny
13. Birthplace Poland

MOTHER 14. Maiden Name Bertha Knach
15. Birthplace Poland.

16 (a) Informant George Szymkowiak
(b) Address 708 S. Potomac St.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location German Hill Rd.

18 (a) Funeral director M. W. E. Dyer & Sons
(b) Address Fleet & Lynn Sts.

OCT 13 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/11 1944, at 10:15 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Mitchell, Medical Examiner.
Date signed 10/12/44

VS 151

G21551

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1131a

G21551 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St
(c) Hospital or institution:
Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 year
(e) Length of stay in Baltimore (yrs., mos., or days) 84 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Same
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Layfield.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary Sumita

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860.

8. AGE: Years 84 | Months | Days | If less than one day hr. min.

9. Birthplace Princess Anne Co Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Layfield
13. Birthplace U S A

MOTHER
14. Maiden Name Elizabeth Blaine
15. Birthplace U S A

16 (a) Informant Little Sisters of the Poor
(b) Address 1200 Valley St Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14, 1944 (month) (day) (year)

(c) Cemetery or crematory Princess Anne
Location Somerset Co. Md

18 (a) Funeral director Lula Wedfield
(b) Address 914 Edgemount Ave

19 (a) OCT 13 1944 (Date died, registrar) Huntington Hillen Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1944 at 6 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1944 to Oct 13 1944 and that I last saw h alive on 19

Immediate cause of death Uremic Poisoning — Duration 3 days

Due to Nephritis

Due to Myocarditis

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work? None
(Specify type of place)
(e) Means of injury

23. Signature Ottolie Baker

Address 928 E. North Ave Date signed 10/13/44
M. D.

G21552

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 90B

G21552 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert St.
(c) Hospital or institution: Mercy
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2612 Lanvale & Loretta Aves (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs. Samuel Liberto
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	MARRIED

6 (b) Name of husband or wife Mrs. Nancy Liberto
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 4, 1904

8. AGE: Years	Months	Days	If less than one day
40	8	6	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Bartender
11. Industry or business Tavern Saloon

FATHER
12. Name Samuel Liberto
13. Birthplace Italy

MOTHER
14. Maiden Name Rosalie Liberto
15. Birthplace Italy

16 (a) Informant Samuel Liberto
(b) Address 2612 Loretta ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Old Frederick Road
18 (a) Funeral director Joseph Fasano Sons
(b) Address 203 Belvidere Ave
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

OCT. 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-10 1944, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-26 1944, to 10-10 1944, and that I last saw him alive on 10-10 1944.

Immediate cause of death	Duration
Acute Circulatory Failure	12 hrs.
Due to Myocardial failure post-operatively	30 hrs.
Due to Calcification of the Myocardium	Indefinite
Other Conditions Hepatomegalia Marked Visceromegaly. (Include pregnancy within 3 months of death)	

Date of operation 10-7-44
Major findings of operation: Calcification of the pericardium - marked
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter K. Spalsbery M. D.
Address Mercy Hospital Date signed 10-12-44

1553

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

G21553 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3103 Tosten Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country -

3 (a) FULL NAME Mary Katherine Benzing

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife -

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-44

8. AGE: Years	Months	Days	If less than one day
-	-	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER
12. Name James Benzing
13. Birthplace -

MOTHER
14. Maiden Name Mary Johnson
15. Birthplace Maryland

16 (a) Informant Father
(b) Address 3103 Tosten Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Sherman Mill Road

18 (a) Funeral director Lilly & Zepp, Inc.
(b) Address 402 S. Wolfe Street

19 (a) Filed OCT 18 1944 Huntingdon Valley, Pa.
(b) By [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1944, at 7:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1944 to 10-13 1944 and that I last saw her alive on 10-13 1944.

Immediate cause of death Acidosis and dehydration.

Duration One week

Due to Diarrhea

Due to -

Other Conditions Malnutrition

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operations: -
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Daniel Ehrlich M.D.
Address 1213 Light St. Date signed 10-18-44

G21554

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1939

G21554 Registered No.

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 2213 N. Fulton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry L. Burk

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/7/1882

8. AGE: Years 62 | Months 5 | Days 1 | If less than one day ____hr. ____min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Boot Black

11. Industry or business

FATHER 12. Name Wm. L. Burk
13. Birthplace Talbot Co. Md

MOTHER 14. Maiden Name Annie Levy
15. Birthplace Ann Arundel Co. Md.

16 (a) Informant Ateller Green (daughter)
(b) Address 813 N. Carlton St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/13/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Pk.
Location Balto County, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 Date received by Local Registrar OCT 13 1944 (b) Huntingtor Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/8/1944, at 4:19 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ at ____ M.
(b) Where did injury occur? ____
(c) Did injury occur at home, on farm, industrial place, in public place? ____ While at work? ____
(d) Means of injury ____

23. Signature Chester J. Gulbinski M.D. Medical Examiner.
Date signed 10/6/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

21555

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190a

Registered No. G21555

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 540 Houser St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Lyle

3 (b) If veteran, name war:
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	negro	Child

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1 16 44

8. AGE: Years	Months	Days	If less than one day
	8	26	hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Joseph Avery
13. Birthplace North Carolina

MOTHER
14. Maiden Name Ollie Lyle
15. Birthplace Farmville Va

16 (a) Informant Ollie Lyle
(b) Address 540 Houser Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14, 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Lyon Cemetery
Location Baltimore County Md

18 (a) Funeral director Joseph A. Bruce
(b) Address 419 Fremont Ave

19 OCT 13 1944 (Date rec'd by registrar) Livingston Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1944, at 2:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1944 to Oct 12 1944, and that I last saw h[im] alive on Oct 12 1944.

Immediate cause of death	Duration
Acute Gastro-enteritis	
Due to Mon. Specific Diarrhea	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G. J. Bassett M. D.
Address Provident Hospital Date signed 10/13/44

M. D. B. 1268-6

21556 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G21556

CERTIFICATE OF DEATH 1944

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 S. Rose St. 1 Ward)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. If of foreign birth? 40 yrs. mos. ds.

2. FULL NAME Rose Cwalina

(a) Residence: No. 522 S. Rose St., 1 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Adam Cwalina

6. DATE OF BIRTH (month, day, year) Nov 11 1877

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
66	67	10	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housework

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Thomas Pika

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Mary Mandzvel

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Mrs Eva Mahy

(Address) 522 S. Rose Street

18. BURIAL, CREMATION, OR REMOVAL

Place Rosary Date Oct 14 1944

19. UNDERTAKER John W. Weber

(Address) 401 S. Chester Street

20. Oct 13 1944 Huntington Williams, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 10, 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct 6 '44 to Oct 10 '44

I last saw h alive on Oct 10 1944. Death is said to have occurred on the date stated above, at 8 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Thrombosis	6th
	9
	10

Other contributory causes of importance:

Ventricular fibrillation

Name of operation ..... Date of .....

What test confirmed diagnosis? ..... Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No If so, specify .....

(Signed) Theodore Brida M. D.

(Address) 1200 N. Patterson Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

D 21557. D 21557. D 21557.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 10613

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3510 Gough St.
(c) Hospital or institution: Res.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto. Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3510 Gough St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Gennaro Gigliotti

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Maria Grazia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 16 1872

8. AGE: Years	Months	Days	If less than one day
72	3	24	hr. min.

9. Birthplace ITALY Praticello Cantanzaro (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Gabriele Gigliotti
13. Birthplace Italy

MOTHER
14. Maiden Name Rosa Gigliotti
15. Birthplace Italy

16 (a) Informant Antonio Gigliotti Son
(b) Address 502 S. Rappolo

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 14 44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Cem.
Location German Hill Rd.

18 (a) Funeral director Frank Pelly Nace
(b) Address 322 S. High St.

19 (a) 10-13-44 (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1944, at 11 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1944, to Oct. 10 1944, and that I last saw h[e] alive on Oct. 10 1944

Immediate cause of death Uremia & Coma — Duration 3 hours

Due to Chronic Nephritis — Duration Considerable time

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ronald E. Lyon M. D.
Address 46 Gilbert St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly. Physicians: please write correct age is especially important. MARG... RESERVED FOR BINDING

46200 G21558

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 22a

G21558 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every question is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1310 Mosher St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James R. Willis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Betty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-15-93

8. AGE: Years	Months	Days	If less than one day
50	10	27	hr. min.

9. Birthplace Okla. (Town, county, and state)

10. Usual Occupation Helper in Poultry Store

11. Industry or business

FATHER

12. Name John Willis

13. Birthplace Okla.

MOTHER

14. Maiden Name Julia Z.

15. Birthplace Okla.

16 (a) Informant Parents.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Brooklyn, Md.

18 (a) Funeral director Evans A. Watson

(b) Address 1000 Belvedere Ave

19 (a) Huntington for Williams Mortuary (Signature of local registrar)

OCT 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1944 at 6.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1944 to Oct. 12 1944, and that I last saw him alive on Oct. 12 1944

Immediate cause of death	Duration
Leptospirosis icterohemorrhagica (Weil's disease)	2 weeks
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Weil's disease

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert A. Walters M.D.

Address Johns Hopkins Hosp Date signed 10/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21559 44 30 17 64 78 35 44 28

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21559 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4007 Fourth St.
(c) Hospital or institution:

62 78

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Fourth St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Thornton

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-2107

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Harriet Gisriel
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) July 21, 1866

8. AGE: Years	Months	Days	If less than one day
78.	2	20	hr. min.

9. Birthplace A. A. Co. Md. (Town, county, and state)
10. Usual Occupation Carpenter.
11. Industry or business

FATHER 12. Name Elijah Abraham Thornton
FATHER 13. Birthplace Md.
MOTHER 14. Maiden Name Sarah Ann Simons
MOTHER 15. Birthplace Md.

16 (a) Informant Mrs Harriet Thornton
(b) Address 4007 4th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 11 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Annapolis Blvd.
18 (a) Funeral director John F Henry Inc, Funeral Home
(b) Address 215 Light St.
19 (a) (Division Registrar) (b) (District) Washington for Williamsville, Md.

OCT 13 1944

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 11 1944 at 10:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 1944 to Oct 11 1944 and that I last saw h[illegible] alive on Oct 11 1944.

Immediate cause of death Cerebral Hemorrhage — Duration

Due to Hypertension CV disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 302 Patapsco Av Date signed 10/17/44

G21560

461116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21560 Registered No. 1330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) 7

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 S. Bonsal St. (If rural give location)
(e) Citizen of foreign country? Bonsal (Yes or No)
If yes, name country

3 (a) FULL NAME Mathilda Mallon

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-15-72

8. AGE: Years 72 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name David Brandl
13. Birthplace Germany.

MOTHER — 14. Maiden Name Elizabeth Gebhart.
15. Birthplace Germany.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 16 44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore Co.

18 (a) Funeral director Wm Fiansford Sr.
(b) Address 1448 Eastern Ave.

19 (a) (Registrar) Huntington Williams M.D.

OCT 13 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944, at 735 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 20 1944, to Oct. 11 1944, and that I last saw h.. alive on Oct 11 1944.

Immediate cause of death Uremia — Duration

Due to Chronic pyelonephritis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Josephine E. Renshaw M. D.
Address Johns Hopkins Hospital Date signed 10/11/44

G21561

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 192 B

G21561

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 Cambria St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roland Offer

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-7283

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	married

6 (b) Name of husband or wife Adele

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-1906

8. AGE: Years	Months	Days	If less than one day
38	7	18	hr. min.

9. Birthplace Brooklyn md
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Claude Offer
13. Birthplace Baltimore md

MOTHER
14. Maiden Name Rosie
15. Birthplace Va

16 (a) Informant Mrs. Adele Offer
(b) Address 104 Cambria St.

17 (a) Burial (b) Date thereof 10-13-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location C Henry Hill

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 13 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 19 44, at 7:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 19 44 to Oct 10 19 44, and that I last saw h/ alive on Oct 10 19 44

Immediate cause of death Rheumatic Heart Disease — Duration

Due to

Due to

Other Conditions Mitral Insufficiency, Aortic Stenosis, Coronary Thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Banfield M. D.
Address Provident Hospital Date signed 10/14/44

G21562

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G21562 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4004 Belvieu Ave.,
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

1510

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Belvieu Ave.,
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen A. Wampler,

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 10, 1877

8. AGE: Years	Months	Days	If less than one day
67	9	2	hr. min.

9. Birthplace Westminister, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business at home

FATHER
12. Name Francis A. Wampler
13. Birthplace Westminister, Md.

MOTHER
14. Maiden Name Franceanna Byers,
15. Birthplace Westminister, Md.

16 (a) Informant Miss Laura Wampler,
(b) Address 4004 Belvieu Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Kriders Cemetery,
Location Carroll County, Md.

18 (a) Funeral director C. Vernon Lemmon,
(b) Address 4611 Park Heights Ave.,

19 (a) OCT 13 1944 [illegible] Md.

VS 180

MEDICAL CERTIFICATION 11.30

20. DATE OF DEATH October 12, 1944, at A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/15 1943, to 10/12/ 1944, and that I last saw her alive on 10/12/ 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Uremia	4-6 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Russell M. D.
Address 3902 Groveland Ave. Date signed 10/13/44

G21563

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21563 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood and Green
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arundel
(c) City or town rural, Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. George A. Jenkins farm
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME Albert Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: male | 5. Color or race: colored (Ht) | 6 (a) Single, married, widowed, or divorced: infant

6 (b) Name of husband or wife —

6 (c) If alive, give age 1 mo

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years — | Months 1 | Days — | If less than one day — hr. — min.

9. Birthplace Pasadena Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Eddie Robinson
13. Birthplace — N. Carolina

MOTHER
14. Maiden Name Viola Johnson
15. Birthplace — Md.

16 (a) Informant Viola Johnson
(b) Address Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory [illegible]
Location [illegible]

18 (a) Funeral director [illegible]
(b) Address Annapolis Md.

19 (a) OCT 13 1944 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944, at 2 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944, to Oct 11 1944, and that I last saw him alive on Oct 10, 1944.

Immediate cause of death respiratory failure — Duration —

Due to malnutrition —

Due to diarrhea —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Kenneth M. Bowers M. D.

Address University Hospital Date signed 10-12-44

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21564

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161a

G21564 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Cheasdpeake Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Cunningham

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1944

8. AGE: Years | Months | Days | If less than one day: 14 hr. 5 min.

9. Birthplace Franklin Square Hospital (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Horace Cunningham
13. Birthplace

MOTHER
14. Maiden Name Jean (Cunningham)
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 13 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 7 1944, at 11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 7 1944 to Oct. 7 1944, and that I last saw him alive on Oct. 7 1944

Immediate cause of death: Congenital Bilateral Atelectasis — Duration: 14 hours
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Congenital Bilateral Atelectasis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Meyers M.D.
Address Franklin Sq. Hosp. Date signed 10/10/44

2232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21565 G21565

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1161c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 W. Lexington St.
(c) Hospital or institution: Volunteers of America Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 d.
(e) Length of stay in Baltimore (yrs., mos., or days) 10 d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto - 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 516 E. North Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY CATHERINE OSBORNE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3 1944

8. AGE: Years | Months | Days: 9 | If less than one day: hr. min.

9. Birthplace Balto, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Howard Lyon
FATHER 13. Birthplace Portsmouth, Ohio

MOTHER 14. Maiden Name Mary Osborne
MOTHER 15. Birthplace Balto, Md

16 (a) Informant Mary Osborne
(b) Address 516 E. North Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 13 1944 (Date rec'd by registrar) Hunter Williams M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1944, at 3:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1944, to Oct 12 1944, and that I last saw h-w alive on Oct 12 1944.

Immediate cause of death	Duration
Erysipelas Bacteria Infection	9 days
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Reginald Gorge M. D.
Address Volunteers of America Hos Date signed 10/13/44

2233

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be given as fully as supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BI ING

G21566

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1119a

G21566 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied—the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 418 W Lexington St
(c) Hospital or institution: Volunteers of America Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d.
(e) Length of stay in Baltimore (yrs., mos., or days) 9d.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. - 24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. East Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DANNIE RAY CROCKETT

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 3 1944

8. AGE: Years	Months	Days	If less than one day
		9	hr. min.

9. Birthplace Balto, Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Raymond Harold Crockett
13. Birthplace Tangier, Va.

MOTHER
14. Maiden Name Helen Payne
15. Birthplace Tangier, Va.

16 (a) Informant Helen Crockett
(b) Address 108 S. East Ave

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 13 1944

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 13 1944 (Date rec'd by registrar) Hunter for Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1944 to Oct. 12 1944, and that I last saw him alive on Oct 12 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Infectious diarrhea	9 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Tapp M. D.
Address Volunteers Hospital Date signed 10/13/44

12251

G21567

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No. G21567

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1572 Richland St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years	Months	Days	If less than one day
85			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location UNIVERSITY MEDICAL SCHOOL OCT 13 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (Date rec'd by registrar) OCT 13 1944 Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 4 1944, at 1 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Arteriosclerotic cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Foster M.D.
Medical Examiner.
Date signed Oct 5 1944

2231

G21568

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G21568 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 933 Rutland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Hurst.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black.	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years	Months	Days	If less than one day
44?			hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ? ?
13. Birthplace ? ?

MOTHER
14. Maiden Name Ruey ?
15. Birthplace ? ?

16 (a) Informant Beards -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 14/44 (month) (day) (year)

(c) Cemetery or crematory
Location Farmville Virginia

18 (a) Funeral director Mrs. Robert L Ellison Jr.
(b) Address 1129 N. Caroline St.

19 (a) OCT 13 1944 Registrar

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 12 1944, at 5.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct- 11 1944 to Oct- 12 1944 and that I last saw him alive on Oct- 12 1944.

Immediate cause of death	Duration
Pulmonary edema	1 day
Due to Arteriosclerotic cardiovascular disease & myocardial ?	?
Due to failure	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:
anatomical diag. 10/12/44.

of autopsy Arteriosclerotic heart disease

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Hatting M. D.
Address Johns Hopkins Hosp Date signed 10/13/44

Printing for Williams, Md.

G21569

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

G21569 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3728 E Fornland Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3728 E. Fornland Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida E. Bennett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Wm. T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17 1870

8. AGE: Years	Months	Days	If less than one day
74	3	20	hr. min.

9. Birthplace Balto - Md.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name James H. Hunter
13. Birthplace Balto - Md.

MOTHER
14. Maiden Name Laura V. Cloud
15. Birthplace Balto. Md.

16 (a) Informant Miss Helen Bennett
(b) Address 3728 E. Fornland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location Wash Ave

18 (a) Funeral director John C. Hilvard
(b) Address 3004 E. Balto. St.

13 1944 (b) Registrar
(Date received by registrar)
Huntington Williams M.D.

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11th 1944 at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9, 1944 to Oct. 11, 1944 and that I last saw h alive on Oct 11, 1944.

Immediate cause of death Primary Carcinoma of Liver — Duration

Due to —

Due to —

Other Conditions Senile Cholecystitis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John Constantine MD M. D.

Address 23 E N Gay St Date signed 10-12-44

G21570

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21570 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2528 W. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) D
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2528 W. Baltimore St
(If rural give location)
(e) If foreign born, how long in U. S. A.? 20 years

3 (a) FULL NAME Robert J. Bothwell

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 214-01-1806

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Buena V. Bothwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17, 1878

8. AGE: Years 66 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Saul, Quebec (Town, county, and state)
10. Usual Occupation Watchman
11. Industry or business Retired

FATHER
12. Name Thomas Bothwell
13. Birthplace Canada

MOTHER
14. Maiden Name Ellen Murphy
15. Birthplace Canada

16 (a) Informant Buena V. Bothwell
(b) Address 2528 W. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cemetery
Location Baltimore, Maryland

18 (a) Funeral director George H. Stalwal
(b) Address 101 Frederick Avenue

19 OCT 13 1944 (b) Huntingtown, Williamsport, Md.
(Date rec'd by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1944, at 5:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 12 1944 to Oct 12 1944, and that I last saw h[illegible] alive on Oct 11 1944

Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease — Duration

Due to

Due to

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert Scagnetti M. D.
Address 1724 W Lombard St Date signed 10-12-44

G21571 #61796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21571 / 1571 M

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Arlington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2911 S. Woodrow St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Gannon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-16-44

8. AGE: Years | Months: 7 6 | Days: 2 7 | If less than one day: hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thos. Gannon
13. Birthplace Mass.

MOTHER 14. Maiden Name Rosa Jacobs
15. Birthplace Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10-13-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Washington, D C

18 (a) Funeral director Wm J. Eichner & Son
(b) Address Balto, Md.

(a) Date received (Registrar) (b) Huntington Williams, M.D.

OCT 13 1944

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12 1944 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1944 to Oct 12 1944 and that I last saw him alive on Oct 12 1944

Immediate cause of death	Duration
Hemorrhage	
Due to Carcinoma	
Due to	
Other Conditions Biliary cirrhosis & biliary atresia	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton O. Gowan Jr. M.D.
Address Date signed

G21572

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21572 / 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4100 Maine ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-10
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4100 Maine ave (If rural give location)
(e) Citizen of foreign country? E (Yes or No)
If yes, name country

3 (a) FULL NAME Genevieve Anna Jeppi

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John Jeppi
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 27 1870

8. AGE: Years	Months	Days	If less than one day
74	3	13	hr. min.

9. Birthplace Italy (town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

FATHER
12. Name Salvatore Maranto
13. Birthplace Italy

MOTHER
14. Maiden Name Rosario Curcio
15. Birthplace Italy

16 (a) Informant Mr Jos Jeppi
(b) Address 4100 Maine ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Rd
18 (a) Funeral director J. H. Emmert
(b) Address Hollick & Wilson Huntingtown, Md

19 (a) Date received by Registrar OCT 14 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1944, at 4 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1 1944 to Oct 10 1944, and that I last saw h— alive on Oct 9 1944.

Immediate cause of death Chronic Myocarditis — Duration

Due to —

Due to —

Other Conditions Diabetes

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury —

23. Signature Albert Scagnetti M. D.
Address 1724 W Lombard St Date signed Oct 13 '44

G21573

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. G21573

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert st.
(c) Hospital or institution Mercy Hosp. 9-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days-
(e) Length of stay in Baltimore (yrs., mos., or days) 16 yrs-

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 E. 36th st.
(If rural give location)
(e) Citizen of foreign country? yes (Yes or No)
If yes, name country Russia

3 (a) FULL NAME Leon Tallen
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. widower

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown 1872

8. AGE: Years 72 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace ?

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Dr. L. C. Tallen
(b) Address 1026 E. 36th st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 44 (month) (day) (year)

(c) Cemetery or crematory
Location New Brunswick N. J.

18 (a) Funeral director Jos. H. Valentine
(b) Address 2326 Aiken st.

19 OCT 14 1944 (Date rec'd by registrar) (b) Harrington Williams M.D.

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH October 13 1944 at 2.02 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-11-1944 to 10-13-1944 and that I last saw him alive on 10-13-1944

Immediate cause of death	Duration
Cardiac failure.	
Due to coronary thrombosis	
Due to	
Other Conditions Enlarged prostate-bronchiectasis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations
of autopsy: Myocard. infarc.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. William H. Osborne M. D.
Address Mercy hosp. Date signed 10-13-44

VS 150

RESERVED FOR BINDING MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

921574
AB-89236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G21574
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2mos-12days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5 North Exeter St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Lewis Terriel Martin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M.
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17-1866

8. AGE: Years 78 | Months 3 | Days 16 26 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Night Clerk

11. Industry or business

FATHER
12. Name William Martin
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Thurber
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16-44 (month) (day) (year)
(c) Cemetery or crematory St. Marys Hampden
Location Roland & 36th St

18 (a) Funeral director Wiseman Comfort Inc.
(b) Address 217 St Paul St

19 (a) OCT 14 1944 (Date received by Local Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13- 1944, at 10A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1944, to 10-13- 1944, and that I last saw h im alive on 10-13- 1944.

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary tuberculosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp. Date signed 10/13/44

G21575

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21575 Registered No. 1190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 832 Hollins St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 832 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Nancy Mary Taylor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-23-44

8. AGE: Years	Months	Days	If less than one day
		20	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER 12. Name Frank Taylor
13. Birthplace New York

MOTHER 14. Maiden Name Audrey Rennel
15. Birthplace Baltimore Md

16 (a) Informant Audrey Taylor.
(b) Address 832 Hollins St

17 (a) Burial - (b) Date thereof Oct 14-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross Cem. A.A. Co.
Location

18 (a) Funeral director Bernard C Hale
(b) Address 121 E West St

19 (a) (Date received by registrar) OCT 14 1944 Registrar Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1944, at 6:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-23 1944 to 10-13 1944 and that I last saw h alive on 10-13 1944

Immediate cause of death: Diarrhea infantile.
Due to Malnutrition
Due to Marasmus

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
20 da

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph G Lowndes
Address 676 Wall Blvd Date signed 10/13/44 M.D.

G21576

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21576 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2230 Lake Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2230 Lake Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME August W. Knoedler

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-07-6407

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Marie M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-30-1899

8. AGE: Years	Months	Days	If less than one day
44	9	14	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Supt. Electrical Contractor
11. Industry or business

FATHER
12. Name George Knoedler
13. Birthplace Germany

MOTHER
14. Maiden Name Matilda Buschere
15. Birthplace Wash. D.C.

16 (a) Informant Mrs Marie Knoedler
(b) Address 2230 Lake Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Parkville, Md.

18 (a) Funeral director H. J. Rych
(b) Address 5305 Harford Rd.

19 (a) Filed (Where filed by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1944, at 2 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Oct 13 1944, and that I last saw h[illegible] alive on Oct 13 1944

Immediate cause of death	Duration
Respiratory Failure	3 hrs
Due to Cerebral Hemorrhage.	3 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ed. L. Zimmerman M. D.
Address 9858 Harford Rd Date signed 10/14/44

G21577

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G21577

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) City or County of Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3108 Dillon St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Krisser

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1944

8. AGE: Years	Months	Days	If less than one day
0	0	11	hr. min.

9. Birthplace Doctors' Hospital, Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Miss Eleanor Krisser
15. Birthplace Maryland

16 (a) Informant Hospital chart
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Memorial City Hosp.

18 (a) Funeral director
(b) Address

19 OCT 14 1944 (b) Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944, at 1:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 9 1944 to Oct. 11 1944, and that I last saw her alive on Oct. 11 1944.

Immediate cause of death Cardio-respiratory failure

Due to Prematurity (7½ mos.) with dehydration and acidosis

Due to Diarrhea

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ben F. Montague, Jr. M. D.
Address Union Memorial Hosp. Date signed 10-11-44

(Over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Age correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21578

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a

G21578
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: South Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town North Linthicum
(If outside city or town limits, write RURAL and give town)
(d) Street No. Patapsco Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Howard Hall, Sr.

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/8/1888
8. AGE: Years 56 Months 4 Days 4 If less than one day hr. min.
9. Birthplace Calvert County
(Town, county, and state)
10. Usual Occupation Safety Engineer
11. Industry or business Ocean Acc. & Guarantee
FATHER 12. Name Richard Henry Hall
13. Birthplace Calvert Co. Md.
MOTHER 14. Maiden Name Sarah Lelia Howard
15. Birthplace Calvert Co., Md.
16 (a) Informant Mrs. Louise Hall
(b) Address 12 Patapsco Ave, N. Linthicum
17 (a) Burial (b) Date thereof 10-14-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore, Maryland
18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Penna. Ave.
19 (a) OCT 14 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. R. Wollenweber M.D.
Medical Examiner.
Date signed October 13, 1944.
(OCC)

G21579

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21579

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully applied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2301 Southern Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2301 Southern Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** CHARLES WALTER SMITH

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 215-05-7852

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Annie H. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 17, 1875

8. AGE: Years	Months	Days	If less than one day
69 68	120	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Checker
11. Industry or business

FATHER
12. Name John S. Smith
13. Birthplace Germany

MOTHER
14. Maiden Name Dora K. Haschert
15. Birthplace Balto., Md

16 (a) Informant Miss Dora K. Smith
(b) Address 2301 Southern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/14/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by registrar) OCT 14 1944 (b) Signature Huntington Williams, M.D. Address

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Oct 12 1944, and that I last saw him alive on Oct 12 1944

Immediate cause of death: Carcinoma of lung (rt)

Duration: 6 mos.

Due to

Due to

Other Conditions: arteriosclerotic Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George Baumgartner, M. D.
Address 4868 Harford Av. Date signed 10/13/44.

621580

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. 621580

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balt.
(c) City or town Timonium (If outside city or town limits, write RURAL and give town)
(d) Street No. 12 Northwood Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Kearns (Frank C.

3 (b) If veteran, name war: No
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M.

6 (b) Name of husband or wife Mary V (nee Poe
6 (c) If alive, give age 37 years

7. Birth date of deceased (mo., day, yr.) Mar. 10, 1898

8. AGE: Years	Months	Days	If less than one day
46	7	4	hr. min.

9. Birthplace Balto Co. Md (Town, county, and state)
10. Usual Occupation Maintenance Engr.
11. Industry or business Paint.

FATHER
12. Name Daniel Kearns
13. Birthplace Ireland

MOTHER
14. Maiden Name Julianna Beggin
15. Birthplace Ireland

16 (a) Informant Mrs. F. C. Kearns,
(b) Address Timonium,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17 1944 (month) (day) (year)
(c) Cemetery or crematory St. Joseph's
Location Texas, Balto. Co. Md

18 (a) Funeral director Landon M. Bond
(b) Address Govans, Md

(b) Date received by registrar OCT 14 1944 Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1944, at 3:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1944, to 10/14 1944, and that I last saw h[illegible]M. alive on 10/13 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Francis L. Grumbine M. D.
Address Date signed

G21581

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G21581

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave & Dudland St
(c) Hospital or institution: West Balto Gen Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 26 N. Smallwood Pl. (If rural give location)
(e) Citizen of foreign country? ~ (Yes or No) If yes, name country ~

3 (a) FULL NAME Miss Annie E. Woodlen

3 (b) If veteran, name war ~ | 3 (c) Social Security Account No. ~

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ~

6 (c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.) Apr 6th 1902

8. AGE: Years: 42. | Months: 6 | Days: 6 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Machine Operator.

11. Industry or business Emerson Drug Co.

FATHER 12. Name John J. Woodlen

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Mary T. Hannon

15. Birthplace Ireland

16 (a) Informant Mrs John M-W. Kay

(b) Address 26 N. Smallwood Pl

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral

Location 4300 Old Frederick Rd.

18 (a) Funeral director John J. Cowan & Son

(b) Address 911 N. Gilmor St.

OCT 14 1944 (Date received by Registrar) (b) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1944, at 5:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1944, to 10/12 1944, and that I last saw h~~er~~ alive on 10/12 1944.

Immediate cause of death Subarachnoid Hemorrhage — Duration 1 Day

Due to Malignant Hypertension

Due to HCVD

Other Conditions Chronic Glom. Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature [illegible] M. D.

Address [illegible] Date signed 10/14/44

C21582

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. C21582

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or instt. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 Remington Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John H. David

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years	Months	Days	If less than one day
78			hr. min.

9. Birthplace Lawrenceville, Va. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name John David
13. Birthplace Va.

MOTHER
14. Maiden Name Rosa
15. Birthplace Va.

16 (a) Informant Roosevelt Mayo
(b) Address 701 Dolphin Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Maryland

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Avenue

OCT 14 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1944, at 1:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic cardiovascular disease.
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hub. Wollenweber M.D. (Medical Examiner.)
Date signed October 14, 1944.
per Robert Lee Taylor M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

621583

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. 621583

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1/4 Mile W. of Roland Ave.
(b) Street address Lake Avenue
(c) Hospital or institution: Roland Park, Balto. 10, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County P
(c) City or town Baltimore 10 (If outside city or town limits, write RURAL and give town)
(or Street No. 13 Lake Ave., Roland Park (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Mae Hook

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Geo. W. Hook, Jr.

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Oct. 18, 1898

8. AGE: Years 45 | Months 11 | Days 24 | If less than one day — hr. — min.

9. Birthplace Baltimore Co., Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER
12. Name Eli K. Swem
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Elizabeth Deerholt
15. Birthplace Balto. Co., Md.

16 (a) Informant George W. Hook, Jr.
(b) Address Lake Ave., Roland Park, Balto. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 15 1944 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill Cem.
Location Towson, Maryland.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Maryland.

19 (a) Oct 14 1944 (b) Huntington, Md.
(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1944 to Oct 12 1944 and that I last saw h[illegible] alive on Oct 12 1944

Immediate cause of death: Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hugo J. Welch M. D.
Address 1123-17 Read Date signed Oct 14 44

Hugo J. Welch, M.D.

G21584

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21584

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3615 Fairview Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-8
(e) Length of stay in Baltimore (yrs., mos., or days) 1 Year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3615 Fairview Ave. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT HAYMAN.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ wife Mabel Hayman.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1891

8. AGE: Years	Months	Days	If less than one day
53	8	1	hr. min.

9. Birthplace New York. (Town, county, and state)
10. Usual Occupation Theater Manager.
11. Industry or business

FATHER
12. Name ? Hayman,
13. Birthplace New York.

MOTHER
14. Maiden Name Henrietta Harris,
15. Birthplace New York.

16 (a) Informant Mrs. Mabel Hayman,
(b) Address 3615 Fairview Ave.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/16/44. (month) (day) (year)
(c) Cemetery or ~~crematory~~ Maimonides.
Location Kings County, L.I. N.Y.

18 (a) Funeral dir. Charles Sonnesyn & Son
(b) Address 1902 Eutaw Place.

19 (a) Filed OCT 14 1944 (Registrar) (b) Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13th. 1944 at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/20 1944 to 10/13 1944, and that I last saw ~~him~~ alive on 10/13 1944

Immediate cause of death Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel C. Bogard, Jun. M. D.
Address 1906 W. Balto. St. Date signed 10/13/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

~~M~~ 21585
36 #80106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

Registered No. G21585

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 112 Market Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lane

3 (b) If veteran, name war	3 (c) Social Security Account No.
Yes World War 1	220-07-7315

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1894

8. AGE: Years	Months	Days	If less than one day
50	6	5	hr. min.

9. Birthplace North Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Quentin Lane
13. Birthplace North Carolina

MOTHER
14. Maiden Name Molly Henriche
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-14-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Frederick Road

18 (a) Funeral director A. Lee Oder
(b) Address 46 & 4 York Rd

19 OCT 14 1944 (Date rec'd by registrar) Hunter for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 10, 1944, at 2:15AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 6, 1944, to Oct. 10, 1944, and that I last saw him alive on Oct. 10, 1944.

Immediate cause of death	Duration
Heart failure	24 hrs
Due to Malignancy of parotid	1 year
Pulmonary T.B.a.	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto. City Hosp. Date signed 10/13/44

MARG... RESERVED FOR B...ING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2 G21586

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21586 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hosp. 9-6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2757 Tivoly Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Berkemeier

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife. Late - John H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15, 1872

8. AGE: Years	Months	Days	If less than one day
72	11	28	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county and state)

10. Usual Occupation House wife

11. Industry or business —

FATHER
12. Name Frederick Geuger
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Rehling
15. Birthplace Balto.

16 (a) Informant John E. Knickman
(b) Address 1814 E. 28th St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave & Longwood St

18 (a) Funeral director Harry H. Wilson
(b) Address 4101 Edmondson Ave

19 (a) OCT 14 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1944, at 5:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1944, to 10-13 1944, and that I last saw h[illegible] alive on 10-13 1944.

Immediate cause of death Hypostatic pneumonia — Duration Two weeks

Due to C-V Accident

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Ehrlich M.D.
Address 1213 Light St Date signed 10-13-44

G21587

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21587

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 Hennion St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent
(c) City or town Galena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William T. Wood.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Sarah L. Camp
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1861

8. AGE: Years	Months	Days	If less than one day
83	8		hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Plumber

FATHER
12. Name John Wood
13. Birthplace Md

MOTHER
14. Maiden Name
15. Birthplace Md

16 (a) Informant Thomas B. Wood
(b) Address 420 Hennion St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-44 (month) (day) (year)
(c) Cemetery or crematory
Location Galena, Kent Co. Md.

18 (a) Funeral director Harry A. Mitzke
(b) Address 1018 Edmondson Ave

OCT 14 1944
(Date rec'd by registrar) (b) Livingston Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 12 1944 at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to Oct 12 1944 and that I last saw him alive on Oct 11 1944

Immediate cause of death	Duration
Coronary Occlusion	3 days
Due to Arteriosclerosis	Years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. O. Von Schulzhof M. D.
Address 4618 Edmondson Ave Date signed 10/12/44

G21588 ✗ ✓ G21588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 173

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correctly given. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town 2636 Liberty Parkway (If outside city or town limits, write RURAL and give County) Dundalk
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ruth Millen Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7 1911

8. AGE: Years 33 | Months 1 | Days 6 | If less than one day: hr. min.

9. Birthplace Massachusetts (Town, county, and state)

10. Usual Occupation Telephone Operator

11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Ernest Raymond Miller
13. Birthplace Nova Scotia

MOTHER
14. Maiden Name Daisy Isabelle Cann
15. Birthplace —

16 (a) Informant Mrs. F. F. Baker
(b) Address Statesboro, Georgia

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-14-44 (month) (day) (year)

(c) Cemetery or crematory
Location Miami Florida

18 (a) Funeral director Jerry H. Wilke
(b) Address 440 Edmondson Ave.

19 (a) 10-14-1944 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1944 at 9 A.M. 30

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fat embolism

Due to Fractures of both tibia

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-8-44 at M.
(b) Where did injury occur? Curtiss-Wright Air Port Balto. County, Essex Commun
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Air Plane Crash.

23. Signature H. L. Wollenweber M.D. Medical Examiner.

Date signed 10-13-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

124B

G21589 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1122 W Mulberry
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1122 W Mulberry (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Harris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or wife McCoy Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1904

8. AGE: Years	Months	Days	If less than one day
40 11	8	13	hr. min.

9. Birthplace Yorktown, York Co., Va. (Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name William Burnell
13. Birthplace York Co. Va.

MOTHER
14. Maiden Name Anna Shields
15. Birthplace York Co. Va.

16 (a) Informant McCoy Harris (Husband)
(b) Address 1122 W. Mulberry.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 14 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) (Date rec'd by registrar) Hunting for Williams, M.D. Registrar

OCT 11 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10 1944 at 9P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Oct 10 1944 and that I last saw h[illegible] alive on Oct 9 1944.

Immediate cause of death Advanced Congestive Heart Failure — Duration 8 d

Due to Liver Cirhosis — Duration (2) d

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jas U. Williams Jr M. D.
Address 511 N. Schroeder St Date signed

G21590

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G21590 Registered No.

MARG RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 114 N. Schraeder St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 year

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (County)
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 114 N. Schraeder St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Garner.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Jannie Garner
6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) 6/6/1881.

8. AGE: Years	Months	Days	If less than one day
63	4	7	hr. min.

9. Birthplace Pumphrey, Charles Co Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Common Labor

FATHER
12. Name William Garner.
13. Birthplace Charles Co.

MOTHER
14. Maiden Name Ann Hawkins
15. Birthplace Charles Co Md.

16 (a) Informant Jannie Garner.
(b) Address 114 N. Schraeder St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Charles Co
Location Pumphrey Md

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) OCT 17 1944 (b) Huntington Williams Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12th 1944 at 2:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from April 12 1944, to Oct 12 1944, and that I last saw h[illegible] alive on April 12 1944.

Immediate cause of death (a) Coronary Occlusion — Duration 5 mo.
Due to (b) Hypertension & Interstitial Nephritis. — Duration 5 mo.
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. T. Gusson M. D.
Address 522 N. Arlington Ave Date signed 10/16/44

G21591 ✓ G21591

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADABLE INK. Every item on this certificate should be carefully supplied and the information correctly given. Information is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Md General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 415 George St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Colonel Co Nelson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 216-09-5294

4. Sex: Male | 5. Color or race: Portugal | 6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 49 | Months | Days | If less than one day: hr. min.

9. Birthplace: Va. (Town, county, and state)

10. Usual Occupation: Laborer

11. Industry or business

FATHER
12. Name: Edgar Nelson
13. Birthplace: Va.

MOTHER
14. Maiden Name: —
15. Birthplace: —

16 (a) Informant: James Holmes
(b) Address: 415 George St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-18-44 (month) (day) (year)
(c) Cemetery or crematory: Milford Va.
Location: Va.

18 (a) Funeral director: George B. Nelson
(b) Address: 1303 Pennsylvania Ave

19 (a) OCT 19 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1944, at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed Pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 13, 1944 25/6 10 P.M.
(b) Where did injury occur? Bet Inlaheer Fairfield
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes.
(d) Means of injury Struck by falling Steel

23. Signature Robert E. Graham M.D. Medical Examiner.
Date signed October 14, 1944

G21592

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G21592 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1629 Edmondson Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Martha Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	married

6 (b) Name of husband or wife William Johnson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1888

8. AGE: Years	Months	Days	If less than one day
56			hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant William Johnson
(b) Address 1629 Edmondson ave

17 (a) Burial (b) Date thereof 10-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Peters cem
Location Md

18 (a) Funeral director George S. Kelson
(b) Address 1303 Pressman ST

19 (a) OCT 16 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 11 1944, at 8 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured Liver

Due to

Other Conditions Internal hemorrhage; Colles' Fracture bilateral.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 13/1

(a) Date of injury 10-11-44 12 Noon M.
(b) Where did injury occur? 907 Chauncey Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Yes
(d) Means of injury Fell from 2nd floor outside porch.

23. Signature Howard C. Mullis M.D.
Medical Examiner.
Date signed 10-12-44

PLEASE WRITE PLAINLY, WITH UNFADABLE INK. Every item of information should be carefully supplied. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 181

G21593

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21593
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1330 Presstman St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1330 Presstman (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sottie Lucy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Eddie Lucy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 5 1885

8. AGE: Years 56 | Months 7 | Days 7 | If less than one day: hr. min.

9. Birthplace near Furnace Va (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name Grandison Patterson
13. Birthplace Virginia

MOTHER
14. Maiden Name Savanna Estes
15. Birthplace Virginia

16 (a) Informant Addie Carter
(b) Address 1330 Presstman

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George D. Kelson
(b) Address 1303 Presstman St

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/12 1944, at 16 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/10 1943, to 10/12 1944, and that I last saw her alive on 10/10 1944

Immediate cause of death Diabetes — Duration

Due to Gangrene of foot

Due to Hypertension Arteriosclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dandy Saunders M. D.
Address 1224 Lee Date signed 10/14/44

VS 150

NOTICE

The succeeding document was received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

G21594

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21594

Registered No. ....

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2324 W North Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days 4[illegible] yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2324 W North Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny R. Klatzkin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Louis H. Ephraim
13. Birthplace Russia

MOTHER
14. Maiden Name Esther Korr
15. Birthplace Russia

16 (a) Informant Benjamin Klatzkin
(b) Address 2324 W North Ave

17 (a) Burial (b) Date thereof October 15, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Rose[illegible]
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) OCT 15 1944 Huntington Williams M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 14 1944 at 3 30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Oct 14 1944, and that I last saw [illegible] alive on Oct 10 1944

Immediate cause of death Hypertension — Duration

Due to

Due to

Other Conditions Coronary Thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature M. Ephraim M. D.

Address 4436 35th St Date signed 10/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21595

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21595

CERTIFICATE OF DEATH 119a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 Briscoe St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 Briscoe St.
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Robert E. Young

3 (b) If veteran, name war No | 3 (c) Social Security Account No. No

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Infant

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1944

8. AGE: Years | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name John Young
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Ora Boucher
15. Birthplace Va

16 (a) Informant John Young
(b) Address 1029 Briscoe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16, 1944 (month) (day) (year)
(c) Cemetery or crematory Leduc Hill
Location Baltimore

18 (a) Funeral director D. Howard Evans
(b) Address 1400 St Paul St

OCT 15 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1944, at 4.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 13 1944 and that I last saw him alive on Oct 13 1944

Immediate cause of death Enteritis | Duration 2 dys
Due to Colitis | 10 dys
Due to
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. O. T. Campbell M. D.
Address 1644 Harlem Date signed 10/14/44

G21596

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

✓ G21596 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days

2. USUAL RESIDENCE OF DECEASED:
(a) State [illegible] (b) County
(c) City or town [illegible]
(If outside city or town limits, write RURAL and give town)
(d) Street No. [illegible] 12
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country V

3 (a) FULL NAME Frances [illegible]

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: [illegible]

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 | Months | Days | If less than one day: hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Samuel [illegible]
13. Birthplace

MOTHER
14. Maiden Name Raffael [illegible]
15. Birthplace

16 (a) Informant Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-15-44 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel
Location Southern Ave

18 (a) Funeral director Jack & Levi Lee
(b) Address 1439 E. Balt St.

OCT 15 1944 Huntington Williams, M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 19 44 at 12:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 19 44 to 10/14 19 44, and that I last saw her alive on 10-14 19 44

Immediate cause of death Cardiac Failure — Duration

Due to Hypertensive Cardio-Vascular Disease

Due to

Other Conditions Lobar Pneumonia Left
Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Cliff Ratcliff, Jr.
Address St. Agnes Hosp Date signed 10/14/44

307691
G21597

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21597 Registered No.

CERTIFICATE OF DEATH 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N. Streeper St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME Frank James Kowgl

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	✓

6 (b) Name of husband or wife Josephine
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) 4-22-87

8. AGE: Years	Months	Days	If less than one day hr.	min.
57	0	21		

9. Birthplace Europe (Town, county, and state)
10. Usual Occupation embalmer
11. Industry or business

FATHER
12. Name Joseph Kowgl
13. Birthplace Bohemia Europe

MOTHER
14. Maiden Name Antoine Fretcher
15. Birthplace Bohemia Europe

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 17/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Hill Cem.
Location Philadelphia Road & Hamps Lane

18 (a) Funeral director John C. Mitchell Sons
(b) Address 1960 Eutaw Place

19 (a) OCT 15 1944 (b) Huntington Williams Registrar (Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13- 1944, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2- 1944, to 10-13- 1944, and that I last saw him alive on 10-13- 1944.

Immediate cause of death	Duration
Circulatory and Respiratory Failure	1/4 hour
Due to myocardial infarction	14 days
Due to Arteriosclerotic coronary thrombosis	
Other Conditions Hypertensive and arteriosclerotic cardiovascular disease (Include pregnancy within 3 months of death)	3 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Abraham Seneca M D
Address Johns Hopkins Hosp Date signed 10-13-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21598

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21598

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2357 Sedney Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 69 yrs 4 mo 2d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Balto

(If outside city or town limits, write RURAL and give town)

(d) Street No. 2357 Sedney Ave

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Marie E. Watkins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race Wht | 6 (a) Single, Married, Widowed, or divorced Widow

6 (b) Name of husband ~~or wife~~ Napoleon L.

(c) If alive, give age ~~years~~

7. Birth date of deceased (mo., day, yr.) June 7 1875

8. AGE: Years 69 | Months 4 | Days 7 | If less than one day hr min

9. Birthplace Balto Md

(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Henry Schossicke

13. Birthplace Germany

MOTHER 14. Maiden Name Sa Orth

15. Birthplace Germany

16 (a) Informant Mrs C. Scholle

(b) Address 2357 Sedney Ave

17 (a) Burial (b) Date of interment 10/17

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Pk

Location Frederick Ave

18 (a) Funeral director Geo Reinfrank

(b) Address 1725 N Fremont Ave

19 (a) (Date rec'd by registrar) OCT 15 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1944, at 7 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 7 1944, to Oct 14 1944, and that I last saw her alive on Oct 14 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Paul Schofield

Address 730 Carroll Date signed 10/15 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21599

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46

G21599
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green
(c) Hospital or institution:
Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) (1)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Oakley Village (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Regina Rembold
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/21/1897

8. AGE: Years	Months	Days	If less than one day
47	4	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Sect.
11. Industry or business

FATHER
12. Name John Rembold
13. Birthplace Maryland

MOTHER
14. Maiden Name Matilda Siegman
15. Birthplace Maryland

16 (a) Informant Regina Rembold
(b) Address Oakley Village, Md.

17 (a) Removal (b) Date thereof 10-15-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wash. D.C.

18 (a) Funeral director Joseph Gawler & Sons Inc.
(b) Address 1730-58 Penna Ave Washington D.C.

19 (a) OCT 15 1944 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1944 at 9 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1944 to Oct 14 1944. and that I last saw her alive on Oct 14 1944.

Immediate cause of death	Duration
a Exhaustion + Mal Nourishment	
Due to Lymphosarcoma	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 9/20/44
Major findings of operation: Lymphosarcoma Return
of autopsy: Sound

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature R C Clemmer M.D.
Address Univ Hospital Date signed 10/15/44
Balto. Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21600

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 94a

G21600
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Smith Ave. - Mt. Washington (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Walter J. Greager

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	S/M&L

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: If	Years	Months	Days	If less than one day
about	50			hr. min.

9. Birthplace unemployed (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Allison Greager
13. Birthplace Penna

MOTHER
14. Maiden Name Kuthrun Sauer
15. Birthplace Penna

16 (a) Informant Fannie Funeral Home
(b) Address Shoemaker Co

17 (a) Removal (b) Date thereof 10/10/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Shoemakers Co
Location Shoemakers Co

18 (a) Funeral director Wilson Cook Co
(b) Address 1314 Gaul St

19 (a) (b) Huntington Willis M.D.
(Date rec'd by registrar) Registrar

OCT 15 1944

VS .150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 14 1944, at 1:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 14 1944, to October 14 1944, and that I last saw h[illegible] alive on October 14 1944.

Immediate cause of death: Coronary Thrombosis — Duration: ?

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: coronary sclerosis, arteriosclerosis

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. K. Lampley M. D.

Address University Hospital Date signed 10.5.44

PHYSICIAN
Underline the cause to which death should be charged statistically.

G21601 ✓ G21601

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (42)

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3009 Herbert St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 10
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Herbert St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Sylvester Hutson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 5, 1873

8. AGE: Years	Months	Days	If less than one day
70	10	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Interior De

11. Industry or business

FATHER
12. Name William H. Hutson
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Mary Anaberg
15. Birthplace Hamburg, Germany

16 (a) Informant Herbert Shilling
(b) Address 24 N Wheeler Ave

17 (a) Burial (b) Date thereof 10-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Baltimore, Md.

18 (a) Funeral director Loring Byers
(b) Address 5005 Park Heights Ave

19 (a) ..... (b) .....
(Date rec'd by registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1944 at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 7/10 1944 to 10/12 1944, and that I last saw him alive on 10/12 1944.

Immediate cause of death
(Enter only one cause per line for (a), (b), and (c).)
(a) Cerebral Hemorrhage
(b)
Due to
(c)
Due to
Other Conditions

Duration
(a)
(b)
(c)

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature ..... M. D.
Address ..... Date signed 10-12-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR B...ING

G21602

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

117a

G21602 Registered No.

MARGINS RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Redwoods Green

(c) Hospital or institution: University

(d) Length of stay in hospital or inst. (~~yrs.~~, ~~mos.~~, or days) 11

(e) Length of stay in Baltimore (~~yrs.~~, ~~mos.~~, or days) 12

2. USUAL RESIDENCE OF DECEASED:

(a) State NY (b) County

(c) City or town Brooklyn (If outside city or town limits, write RURAL and give town)

(d) Street No. 585 E. 34th St (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George P. Lustig

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Florence Lustig

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1892

8. AGE: Years	Months	Days	If less than one day
52	2	21	hr min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Service Engineer

11. Industry or business Bendix Aviation

FATHER
12. Name Unknown
13. Birthplace GERMANY

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant George Lustig

(b) Address 585 - E 34th St Brooklyn, NY

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17 - 44 (month) (day) (year)

(c) Cemetery or crematory Brooklyn New York

Location

18 (a) Funeral director Chas P Towell

(b) Address 2427 Edmondson Ave

19 (a) (Date received by Local Registrar) (b) Registrar

OCT 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-44 19 , at 4:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1944, to 10-14 1944, and that I last saw him alive on 10-13 1944.

Immediate cause of death Peritonitis, generalized — Duration

Due to perforated gastric ulcer

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-3-44

Major findings of operation: perforated gastric ulcer

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature W D Lynn M. D.

Address Univ Hosp Date signed 10-14-44

W.D. Lynn

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21603

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G21603

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1930 Ridghill Ave.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1930 Ridghill Ave. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME BIRDIE MAY SACKS

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1901

8. AGE: Years	Months	Days	If less than one day
42	9	25	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Henry Sachs
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Mary Mannion
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Lillian Wiest
(b) Address 2308 Mosher St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 16 1944 (Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1944 at 8:00P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Oct 13 1944, and that I last saw h alive on Oct 13 1944.

Immediate cause of death Carcinoma of left breast — Duration 2 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Ackerman M.D.
Address 1921 W North Ave. Date signed 10/14/44 M. D.

G21604 ✓ G21604

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§3a Registered No. 6xx)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1520 Clifton Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** William H. Sheiblein

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Separated

6 (b) Name of husband or wife: Hattie T.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, ~~1866~~ 1867

8. AGE: Years	Months	Days	If less than one day
77 78	4	8	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Retired Carpenter

11. Industry or business

FATHER
12. Name John F. Sheiblein
13. Birthplace Balto., Md.

MOTHER
14. Maiden Name Sarah A. Parrott
15. Birthplace Balto., Md.

16 (a) Informant Mrs. J. Frank Sheiblein
(b) Address 4206 Wilkins Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) (Registrar)

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1944, at 11:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)

Date signed 10-14-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21605

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92D

Registered No. G21605

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2420 N. Calvert St.
(c) Hospital or institution:

12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2420 N. Calvert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ELIZABETH DUGAN

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife -- Albert I. Dugan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 15, 1858

8. AGE: Years	Months	Days	If less than one day
86	7	28	hr. min.

9. Birthplace Chestertown, Md.
(Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name John Wesley Parsons
13. Birthplace Kent Co., Md.

MOTHER
14. Maiden Name Martha Arnold
15. Birthplace Kent Co., Md.

16 (a) Informant Mr. Joseph H. Dugan
(b) Address 2420 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 16 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 15 19XX, to Oct 13 19 44 and that I last saw h[illegible] alive on Oct 11 19 44

Immediate cause of death	Duration
Chronic Valvular Heart Disease	3 yrs.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey M. D.
Address 1928 Penna Ave Date signed 10/17/44

1606

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 V

Registered No. C21606

PLACE OF DEATH:
(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Prov. Hospt. W

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 900 Argyle Ave (If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4 1895

8. AGE: Years 49 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER
12. Name Robert Lee
13. Birthplace Va.

MOTHER
14. Maiden Name Taylor
15. Birthplace Va.

16 (a) Informant Louise Lee
(b) Address 900 Argyle Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Huntington Wilson, Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1944 at 2 9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 19 44 to Oct 13 1944
and that I last saw h/m alive on Oct 13 1944.

	Duration
Immediate cause of death: Chronic Myocardial Failure	
Due to: Chronic Myocarditis	
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

Report of autopsy: Aneurysm of Aorta

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H H Bonfiels M.D.

Address Provident Hospital Date signed 10/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21607 — 89854

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1937

Registered No. G21607

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 304 E. 20½ St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Hewitt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1879

8. AGE: Years	Months	Days	If less than one day
65 ?	?	?	hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation ?
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
19 OCT 16 1944 (Date rec'd by registrar) (b) Huntington Wilson Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-5 1944 at 6:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/18 1944, to 10-5 1944, and that I last saw him alive on 10-5 1944

Immediate cause of death Bronchopneumonia — Duration 18 days

Due to

Due to

Other Conditions Hypertensive cardiovascular disease — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Leech
Address Balt. City Hosp Date signed 10/12/44 M. D.

G21608

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1316 Registered No. G21608

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 205 N. Amity St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Martha Abney Williams

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: Negro
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Eugene
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3/13/1906
8. AGE: Years 38 | Months 7 | Days – | If less than one day hr. min.
9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name James Miller
13. Birthplace Va.

MOTHER
14. Maiden Name Carrie Carroll
15. Birthplace Baltimore, Md

16 (a) Informant Eugene Williams (Hus).
(b) Address 205 N. Amity St apt. 5

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave

19 (a) Date received OCT 16 1944 (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION 40

20. DATE OF DEATH Oct. 13 1944, at 1 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944, to Oct 13 1944, and that I last saw h[illegible] alive on Oct 13 1944.

Immediate cause of death: Chronic Nephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H H Bagnall M. D.
Address Provident Hospital Date signed 10/13/44

G21609

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G21609

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd + Calvert Sts

(c) Hospital or institution: Union Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 days

(e) Length of stay in Baltimore (yrs., mos., or days) 16 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Frederick

(c) City or town Union Bridge Route #1.
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Margaret Bertha Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Married

6 (b) Name of husband or wife John William Davis

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1889

8. AGE: Years	Months	Days	If less than one day
54	10	19	hr. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Mr. Theodore Starner

13. Birthplace Md

MOTHER 14. Maiden Name Mary Fleagle

15. Birthplace Md

16 (a) Informant John Wm. Davis

(b) Address Union Bridge, Md. Route #1

17 (a) Burial (b) Date thereof Oct 18 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Brust Church

Location Carroll County Md.

18 (a) Funeral director C. D. Gilbert Son

(b) Address Taneytown, Md.

19 (a) Date received (b) Registrar

OCT 16 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1944, at 4½ A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1944, to 10-16 1944, and that I last saw her alive on 10-16 1944 1¼ P.M.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Peritonitis, pneumonia, septicemia	5 days.
Due to Adenocarcinoma of cecum	2 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-11-44

Major findings of operation: Adenocarcinoma, colloid type, cecum.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Glenn A. Bowe, M.D.
M. D.

Address Union Memorial Hospital Date signed 10/17/44

021510

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. 021610

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 West Fayette
(c) Hospital or institution:
Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 23
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2123 Boyd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Colhouer

3 (b) If veteran, name war / 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-44 7 days

8. AGE: Years | Months | Days: 1 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Edward Wm Colhouer
13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Esther Cohen
15. Birthplace Baltimore Md

16 (a) Informant Edward W. Colhouer
(b) Address 2123 Boyd Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-44 (month) (day) (year)
(c) Cemetery or crematory Westen
Location Balto. Md.

18 (a) Funeral director George Leyderbrand
(b) Address 1111 Fredrick Avenue

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1944 to 10-15 1944, and that I last saw her alive on 10-15 1944.

	Duration
Immediate cause of death: Congenital Atelectasis	
Due to: Prematurity 27 wks	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond Long M.D.
Address 1 E. Lexington St. Date signed 10/16/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21611

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21611

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 920 N. Kenwood Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 920 N. Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

3 (a) FULL NAME Frederick William Wiegand

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-03-9927

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Katherine Eberwein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22, 1892

8. AGE: Years	Months	Days	If less than one day
52 yrs.	8	21	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Asst. Chef
11. Industry of business Miller Brothers

FATHER
12. Name Adam Wiegand
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Katherine Wiegand
(b) Address 920 N. Kenwood Avenue

17 (a) Burial (b) Date thereof 10/17/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601-03 E. Madison Street

19 (a) OCT 16 1944 (b) Signature of Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1944, at 3:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 15 1944 to Oct. 13 1944, and that I last saw h[illegible] alive on Oct. 12 1944

Immediate cause of death: Coronary Thrombosis — Duration: Days
Due to: Coronary Heart Disease — ?
Due to: Arteriosclerosis
Other Conditions: Chr. Bronchitis — ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address 900 E. Fort Ave. Date signed Oct 17 1944 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG[illegible] RESERVED FOR B[illegible]DING

VS 110

G21612

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126

Registered No. G21612

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Entire

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 320 Whitridge Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Hill

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. 219-01-1224

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian Hill

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) March 17th 1894

8. AGE: Years 50 | Months 6 | Days 27 | If less than one day: hr. min.

9. Birthplace Providence R.I. (Town, county, and state)

10. Usual Occupation Steam Fitter

11. Industry or business Journeyman

FATHER
12. Name (Unknown) Hill
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Lillian Hill
(b) Address 320 Whitridge Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Bolk Jr.
(b) Address 1217 St. Paul St.

19 (a) Date received by Local Registrar (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1944, at 12:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/7/1944, to 10/14/1944, and that I last saw him alive on 10/14/1944.

Immediate cause of death: Cerebral Hemorrhage, Secondary Coronary Occlusion — Duration: 8 days

Due to: Hypertension

Due to:

Other Conditions: Hypertrophic Arthritis

(Include pregnancy within 3 months of death)

Date of operation 10/9/44

Major findings of operation: Chole Lithiasis + Adhesions

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Martin, Jr. M.D.

Address Bon Secours Hosp. Date signed 10/14/44

G21613 A

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21613
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 Druid Hill Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Cooper

3 (b) If veteran, name war: World War I

3 (c) Social Security Account No. —

4. Sex: M

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Irene

6 (c) If alive, age: 23 | 8[illegible]

7. Birth date of deceased (mo., day, yr.): August 4, 1882

8. AGE: Years 55 57 | Months 1 | Days 18 | If less than one day: hr. min.

9. Birthplace: Balto, Md
(Town, county, and state)

10. Usual Occupation: Custodian

11. Industry or business: Public Bldgs.

FATHER
12. Name: Unknown as a Cooper
13. Birthplace: Balto, Md

MOTHER
14. Maiden Name: Unknown Preston
15. Birthplace: Balto, Md

16 (a) Informant: Irene Cooper
(b) Address: 1913 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 16 '44 (month) (day) (year)

(c) Cemetery or crematory: Baltimore Nat'l Cem.
Location: Baltimore, Md.

18 (a) Funeral director: Mr. Geo. H. Holland
(b) Address: 1611 Druid Hill Ave.

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 10 1944 at 4 15 M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic myocardial degeneration

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Bratton M.D.
Medical Examiner
Date signed Oct. 11, 1944

VS 151 G 1044

G21614

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21614 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1504 N. Pulaski st
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1504 N. Pulaski St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bella Goodman

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Simon —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1854

8. AGE: Years 90 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Samuel Goodman
(b) Address 905 Lake Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location

18 (a) Funeral director Jacob Lewis Inc
(b) Address 1739 E. Balto. St

OCT 16 1944 (Date received by registrar) By direction of Wilbur M. Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1944, at 4.9 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1944, to Oct 15 1944, and that I last saw her alive on Oct 14 1944.

Immediate cause of death: Cerebral hemorrhage — Duration: 15 days
Due to: Arterio-sclerosis — 5 years
Due to: (Hypertension)
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Frederick Lentz M. D.
Address Temple Garden apts Date signed Oct 15 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21615

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

Registered No. G21615

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2278 N. Bryan St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ewan Mc Kinney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace South Carolina (Town, county, and state)

10. Usual Occupation Day Laborer

11. Industry or business

FATHER
12. Name Charles Mckinney
13. Birthplace S. C.

MOTHER
14. Maiden Name Hattie Darby
15. Birthplace S. C.

16 (a) Informant Sarah Johnson
(b) Address 3206 Fairfield Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 17-44 (month) (day) (year)
(c) Cemetery or crematory York
Location S. C.

18 (a) Funeral director James Astarjo
(b) Address 142 W. Hill St

19 OCT 16 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 9 1944, at 10:38 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Bullet wound of chest.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 9 '44 at 10 P. M.
(b) Where did injury occur? 937 N. Bay St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Shot during altercation

23. Signature H. L. Walker Jr. M.D.
(Medical Examiner.)
Date signed Oct. 10, 1944.

VS 151

G21616

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G21616

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 609 Glenolden Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 609 Glenolden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John J. Schwinger,

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Lena M. Schwinger,
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 26, 1863

8. AGE: Years	Months	Days	If less than one day
81	5	18	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Hardware

FATHER
12. Name John J. Schwinger,
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Miss Emma D. Schwinger,
(b) Address 609 Glenolden Ave.

17 (a) Burial (b) Date thereof October 17, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director George W. Little
(b) Address 2700 Edmondson Ave.

19 (a) OCT 16 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT 14 1944, at 2.45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 19 32 to Oct 14 1944, and that I last saw h[illegible] alive on Oct 13 1944.

Immediate cause of death	Duration
due to Cerebral Hemorrhage with Pneumonia	(1) 1 week
Due to Generalized Sclerosis with	(2) 12 years
Due to Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Mitchell M. D.
Address 2901 Edmondson Ave. Date signed Oct 14 19[illegible]

to be O.K. by Med. Examiner. V

G21617

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G21617

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 Nelson St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 Nelson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Price

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex male

5. Color or race c

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace St Mary's Co.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Nettie Fletcher
15. Birthplace Baltimore Md

16 (a) Informant Thomas Price Jr.
(b) Address 1717 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 16-19 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

19 (a) (Date rec'd by Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1944, at 8 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944 to 10/13 1944, and that I last saw h[illegible] alive on 10/13 1944

Immediate cause of death	Duration
(a) Cardio-Vascular Renal Disease	2 yrs.
Due to (b) Arteriosclerosis	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Graham M.D.
Address 120 Washington Date signed 10/14/44

U.S. 238

for H. H. Graham, by Howard J. Hansen M.D.

G21618 G21618

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) Ward Sud (b) County Balto
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3412 Kentucky Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lawrence Heltzner

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-03-1123

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Margaret Heltzner
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) May 17, 1891

8. AGE: Years	Months	Days	If less than one day
53	5	29	hr. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: Laundry Supervisor
11. Industry or business

FATHER
12. Name: Leonard Heltzner
13. Birthplace: Germany

MOTHER
14. Maiden Name: Barbara Boehm
15. Birthplace: Germany

16 (a) Informant: Mrs. Margaret Heltzner
(b) Address: 3412 Kentucky Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory: Parkwood
Location: Rural

18 (a) Funeral director: Ulrich Funeral Home
(b) Address: 2104-8 Orleans St

19 (a) OCT 16 1944 (Date received by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 13 1944, at 10:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 1944, to Oct 13 1944, and that I last saw him alive on Oct 13 1944.

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Rheumatic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: Rheumatic Heart Disease - Pulmonary
of autopsy: Fibroid - multiple Pulmonary Edema

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature: Jerome Richard Hartman M. D.
Address: Sinai Hosp. Balt. Md. Date signed: 10-14-44

G21619 BALTIMORE CITY HEALTH DEPARTMENT G21619
CERTIFICATE OF DEATH 131a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 N Linwood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 N Linwood Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Etta Theresa Redmore

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Leo H Redmore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1852

8. AGE: Years	Months	Days	If less than one day
92	6	6	hr. min.

9. Birthplace Norristown Pa
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Peter L Carl
13. Birthplace Pa

MOTHER
14. Maiden Name — Keeley
15. Birthplace Pa

16 (a) Informant Leo E Redmore Jr
(b) Address 821 N. Linwood Ave

17 (a) Burial (b) Date thereof Oct 18
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem
Location Woodlawn Md

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Oliver St

19 (a) OCT 16 1944 (b) Hunter [illegible] Registrar
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14th 1944, at 11:50 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1944 to Oct 14 1944 and that I last saw h[illegible] alive on Oct 14 1944 —

Immediate cause of death
Uremia (Chronic nephritis) Duration Oct 7/44
Cardio-vascular-renal Dis 6 yrs
Due to Arterio-Sclerosis 5 yrs
Due to —

Other Conditions —

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Louis F. Krumbein M. D.
Address 722 N. Kenwood Ave Date signed Oct 16/44
LOUIS F. KRUMBEIN, M.
722 N. KENWOOD AVE.

G21620

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21620 Registered No. 937

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Johns Hopkins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 N. Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOTTIE PEAL

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1852

8. AGE: Years	Months	Days	If less than one day
62	3	11	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Pt Home

FATHER
12. Name Joseph Costor
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maria ?
15. Birthplace Unknown

16 (a) Informant Mrs. E.H. Conkling
(b) Address 924 E. Eager Street

17 (a) Burial (b) Date thereof 10-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Laurel Cemetery
Location Belair Rd.

18 (a) Funeral director Wagner Sanders
(b) Address 1412 E. Preston St.

19 (a) OCT 16 1944 (b) Hunter Foster Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1944 at 4:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. T. Waldenmaier M.D.
as Medical Examiner.
Date signed 10-17-44

G21621 BALTIMORE CITY HEALTH DEPARTMENT G21621
CERTIFICATE OF DEATH 119a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: John Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1516 Thame Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Frank

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age 6/11/44

7. Birth date of deceased (mo., day, yr.) 7/ /1944

8. AGE: Years | Months 4 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John W. Frank
13. Birthplace N.C

MOTHER 14. Maiden Name Mary Brisco
15. Birthplace Md

16 (a) Informant John W. Frank
(b) Address 1516 Thame St

17 (a) Burial (b) Date thereof 10-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location L. D. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1944, at 2:45 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Premature, infantile
cause undetermined

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
and Medical Examiner.
Date signed 10-13-44

G21622

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G21622 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 8 W. 25th Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 8 W. 25th St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred P. Crosby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/24/1889 1889

8. AGE: Years	Months	Days	If less than one day
54	11	19	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Darvie J. Crosby
13. Birthplace N. C.

MOTHER
14. Maiden Name Eva Parker
15. Birthplace N. C.

16 (a) Informant Ed. A. Mehrling
(b) Address Bendix - 920 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-44 (month) (day) (year)
(c) Cemetery or crematory Oxford Cem.
Location Oxford, Md.

18 (a) Funeral director J. D. Mitchell & Son, Inc.
(b) Address 1900 Eutaw, Balto.

19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 16 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1944, at 11:20 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Pain death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed October 13, 1944

(Over)

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21623 ✓ G21623 Registered No. 12/a

RESERVED FOR BINDING

MARGIN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2236 E. Lanvale St
(c) Hospital or institution: 9

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2236 E. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur W. Zimmerman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth W. Zimmerman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 28, 1898

8. AGE: Years	Months	Days	If less than one day
46	7	15	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Manager Restaurant
11. Industry or business Self Lunch Room

FATHER 12. Name Samuel Zimmerman
13. Birthplace —

MOTHER 14. Maiden Name Unk
15. Birthplace

16 (a) Informant Elizabeth W. Zimmerman
(b) Address 2236 E. Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location North & Milton Aves

18 (a) Funeral director Howard N. Bligh Jr
(b) Address 4914 Belair Road

19 (a) OCT 16 1944 (b) Huntington Williams, Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1943, to Oct 13, 1944 and that I last saw h[illegible] alive on Oct 13 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to Hypertensive Cardio-Vascular Renal Disease	15 months
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward Wolfe M. D.
Address 1331 E North Ave Date signed 10-16-44

G21624

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21624 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Redwood Sts
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 32

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rosewood Lane (If rural give location)
(e) Citizen of foreign country? N (Yes or No)
If yes, name country

3 (a) **FULL NAME** Bernard Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1, 1911

8. AGE: Years	Months	Days	If less than one day
32	11	15	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Jacob Brown
13. Birthplace Russia

MOTHER
14. Maiden Name Sarah Goldie Rosenblum
15. Birthplace England

16 (a) Informant Jacob Brown
(b) Address 3633 Cottage Ave

17 (a) Burial (b) Date thereof October 16, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Philadelphia Road

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) OCT 16 1944 (Registrar's signature) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1944, at 12 40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1944 to Oct 16 1944, and that I last saw h.wife alive on Oct 16 1944.

Immediate cause of death	Duration
Hemorrhage Internal	
Due to Hypotension	
Due to	
Other Conditions Spontaneous pneumothorax	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) 1944 of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John M. Jernigan M. D.
Address University Hosp. Date signed Oct 16, 1944

G21625

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G21625

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Shutter St (If rural give location)
(e) Citizen of foreign country? Shutter (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Miller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 16-5-88

8. AGE: Years	Months	Days	If less than one day
56 55	-	8	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Miller
13. Birthplace Va

MOTHER
14. Maiden Name Bill Lee
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10 16 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location
18 (a) Funeral director Mrs. Robt. H. Elliott & Daughter
(b) Address 1129 N. Caroline St.
19 (a) (b)
(Date rec'd by registrar) Registrar

OCT 16 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1944 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Oct. 13 1944 and that I last saw him alive on Oct 13 1944

Immediate cause of death: Hypertensive encephalopathy — Duration: 4 days
Due to: Hypertensive cardiovascular disease with myocardial failure
Due to: Arteriolarsclerosis of kidneys
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy Hypertensive cardiovascular renal disease

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Gallen
Address Johns Hopkins Hosp. Date signed 10/21/44 M. D.

PHYSICIAN
Underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21626

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

✓G21626 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 217 E. Heath Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Maryland
(If outside city or town limits, write RURAL and give town)
(d) Street No. 217 E. Heath Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH A. SULLIVAN

3 (b) If veteran, name war ------
3 (c) Social Security Account No. ------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife George C.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 6, 1885

8. AGE: Years	Months	Days	If less than one day
59	5	7	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business Home

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Family
(b) Address 217 E. Heath Street

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/15/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glenburnie, Maryland

18 (a) Funeral director Samuel McCurley
(b) Address 130 E. Fort Avenue

19 (a) (Date received) (b) Registrar Huntington Williams
OCT 16 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1944 at 7:24 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 13 1944, and that I last saw h[illegible] alive on Oct 3 1944

Immediate cause of death Carcinoma of Cervix — Duration 2 yrs.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at P.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Miller M.D. M. D.
Address 122 Pleasant St. Date signed 10/14/44

G21627 — BALTIMORE CITY HEALTH DEPARTMENT — G21627 Registered No.

CERTIFICATE OF DEATH

94a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 N.Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) 58

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland County
(b) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 N.Broadway
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Herman A.Grolock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct.18,1885

8. AGE: Years	Months	Days	If less than one day
58	11	27	hr. min.

9. Birthplace Baltimore,Maryland (Town, county, and state)
10. Usual Occupation Printing Business
11. Industry or business

FATHER
12. Name Gustav C.Grolock
13. Birthplace Germany

MOTHER
14. Maiden Name Augusta Discher
15. Birthplace Germany

16 (a) Informant Miss Alice Grolock
(b) Address 1630 N.Broadway

17 (a) Burial (b) Date thereof 10-17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Taylor Avenue

18 (a) Funeral director Albert L. Hilt
(b) Address 1606 N.Chester Street

19 (a) [illegible] (b) Huntington Williams M.D.
(Signature of local registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1944 at 10.30 A.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 13 1944 to Oct 14 1944 and that I last saw h[illegible] alive on Oct 13 1944.

Immediate cause of death Coronary Thrombosis

	Duration
Due to	
Due to arteriosclerosis (?)	
Other Conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. A. S. Valentine M.D.
Address 732 N.Broadway Date signed Oct 14 1944

Attending Medical Examiner

621628

621628

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Sinai Hospital
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 79
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S. Mount st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frank Doering

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-12-2655

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 14, 1881

8. AGE: Years	Months	Days	If less than one day
63	7	29	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Christian Doering
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Kaisman
15. Birthplace Germany

16 (a) Informant Mrs. Christian Doering
(b) Address 2514 W. Fayette st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-16-44 (month) (day) (year)

(c) Cemetery or crematory Westview
Location Baltimore, Md.

18 (a) Funeral director Frederick A. Cole
(b) Address 1900 W. Lombard st

19 (a) OCT 16 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13, 1944, at 5:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 3, 1944, to Oct 13, 1944, and that I last saw h.im alive on Oct 13, 1944.

Immediate cause of death Carcinoma of Sigmoid, Widespread Metastases, Peritonitis, Jejuno-colic fistulae — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Sept. 25, 1944

Major findings of operation: Carcinoma of Rectum, Sigmoid with liver metastases

of autopsy: Carcinoma of Sigmoid perforation, Peritonitis, Hepatic metastases

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Elmer Hoffman M. D.

Address Sinai Hospital Date signed 10/13/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G21629

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G21629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Saratoga & Calvert sts.
(c) Hospital or institution: Mercy

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2827 O'Donnell St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Antonia (or) Antonina Leyko

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Mr. Julius Leyko
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-1886

8. AGE: Years	Months	Days	If less than one day
58	8 7	13	26 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John A. Kogan
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Kot
15. Birthplace Poland

16 (a) Informant Carolyn A. Leyko
(b) Address 2827 O'Donnell St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17 44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus Cem.
Location Dundalk Ave.

18 (a) Funeral director Stephen J. Szalkowski
(b) Address 1000 S. Kenwood ave.

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Hunting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1944, at 5:57 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-19 1944 to 10-13 1944, and that I last saw h[illegible] alive on 10-13 1944.

	Duration
Immediate cause of death Cardiac - Respiratory Failure	1 week
Due to Widespread adeno-carcinoma - metastasis	1 month
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-22-44
Major findings of operation: Lesion studded w/ metastatic carcinoma nodules
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Walter K. Spalsbury M. D.
Address Mercy Hospital Date signed 10-13-44

G21630

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G21630
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 723 W Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 723 W. Fayette St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 399-16-8923

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mary E. McGee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1866

8. AGE: Years	Months	Days	If less than one day
57	10	9	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Reid Hayden Co.

FATHER
12. Name — Robinson
13. Birthplace unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Mary E. Robinson
(b) Address 723 W. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location 3900 Rd Frederick Rd

18 (a) Funeral director Harry A. Weber
(b) Address 4101 Edmondson Ave

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

OCT 16 1944

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1943, to Oct 14 1944, and that I last saw h[illegible] alive on Oct 14 1944.

Immediate cause of death	Duration
Acute Cardiac Dilation	2 days
Due to Myocarditis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Glassman M. D.
Address 723 W. Fayette St Date signed Oct 16

G21631
AB-87984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21631
Registered No. 1312

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4mos- 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 701 W. Lafayette Ave.
(Street or rural route location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Geneva Lewis

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife Troy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8-1923

8. AGE: Years	Months	Days	If less than one day
20	11	4	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Benjamin Lewis
13. Birthplace Maryland

MOTHER
14. Maiden Name Geneva Williams
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof Oct. 16 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western Star Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George H. Holland
(b) Address 1621 Druid Hill Ave.

19 (a) OCT 16 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-12 1944, at 7.45pM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-13 1944 to 10-12 1944, and that I last saw her alive on 10-12 1944

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 10/13/44

C21632

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. C21632

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Beech Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary B. Fetz

3 (b) If veteran, name war

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1934

8. AGE: Years	Months	Days	If less than one day
10	7	25	hr. min.

9. Birthplace Maryland (Town, county and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name Joseph A. Fetz
13. Birthplace Maryland

MOTHER
14. Maiden Name Anna T. Fader
15. Birthplace Maryland

16 (a) Informant Joseph A. Fetz
(b) Address 3410 Beech Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 19 1944 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location New Freedom Pa

18 (a) Funeral director Clements & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1944, at 4 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy/Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage,

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-15-44 11 A. M.
(b) Where did injury occur? 3410 Beech Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Fell down steps of Home.

23. Signature H. L. Wallenmeier M.D. Medical Examiner.
Date signed October 17 1944

G21633

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

G21633 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sainai Hos.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (~~yrs., mos.,~~ or days) 12 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 310 S. Broadway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Ey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W.	Married

6 (b) Name of husband or wife Bertha

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace [redacted] Balto.
(City, county, and state)

10. Usual Occupation Chauffer

11. Industry or business Hechts Bros.

FATHER
12. Name Edward Ey
13. Birthplace Balto

MOTHER
14. Maiden Name Marguerite Meckelman
15. Birthplace

16 (a) Informant Bertha Ey
(b) Address 310 S. Broadway

17 (a) Burial (b) Date thereof Oct. 17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location O donnell St

18 (a) Funeral director Wm. L. Fialkowski
(b) Address 2007 Eastern Ave

19 (a) OCT 16 1944 (b) Registrar
(Date received)

VE 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1944 to 10/14 1944, and that I last saw him alive on 10/14 1944.

Immediate cause of death Respiratory failure — Duration

Due to Cerebral vasc. accident (cause unknown (probably syphilis)

Due to

Other Conditions Syphilis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leonard Ahern M.D.
Address Sinai Hosp. Date signed 10/17/44

G21634
JL - 70580

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 131a

G21634
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 - 9 - 27 26 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. None (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Richardson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Sept.

6 (b) Name of husband or wife: Klein
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? 1873

8. AGE: Years 71 ? | Months ? | Days ? | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Dan Richardson
13. Birthplace ?

MOTHER
14. Maiden Name Anna Purgy
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Peter R. Williams
(b) Address 322 N Schroeder St

OCT 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13 1944, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Oct 13 1944, and that I last saw him alive on Oct 13 1944.

Immediate cause of death Bronchopneumonia — Duration 8 da

Due to

Due to

Other Conditions Hypertensive cardio-vascular renal disease — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith
Address Balt. City Hosp. Date signed 10/14/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. MARGIN RESERVED FOR BINDING

G21635

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 113 B

Registered No. G21635

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 821 Bradley St - D.O.A.
(c) Hospital or institution: /
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 821 Bradley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Andrew Leon Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years	Months	Days	If less than one day
32			hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andrew Williams
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Williams
15. Birthplace Baltimore Md

16 (a) Informant Mary Johnson
(b) Address 754 W. Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location

18 (a) Funeral director Mrs. Katie A. Williams

(b) Address 322 N. Schroeder St

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1944, at 11:55 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Toxicology Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary TB

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury — at — M.

(b) Where did injury occur? —

(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?

(d) Means of injury —

23. Signature Charles K. Sabatake M.D.
Medical Examiner.

Date signed 10/17/44

VS 151

G21636

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

G21636 Registered No. 2078

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1024 Whatcoat St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs

16 W

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 Whatcoat St (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME Mrs Bertha Ruth Pinkney

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-05-3457

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife James Pinkney (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept ? 1899

8. AGE: Years 45 | Months 1 | Days — | If less than one day ___ hr. ___ min.

9. Birthplace Augusta Ga (Town, county, and state)

10. Usual Occupation Laundress + home work

11. Industry or business Own Laundry & own home

FATHER
12. Name Smith Jones
13. Birthplace Ga.

MOTHER
14. Maiden Name Maria Carter
15. Birthplace Ga

16 (a) Informant Carrie Robinson
(b) Address 1024 Whatcoat St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 15 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Mrs Katie R. Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-13-1944, at 2.4 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-1-1943, to 10-13-1944, and that I last saw her alive on 10-12-1944.

Immediate cause of death Myocarditis — Duration ___

Due to — Duration ___

Due to — Duration ___

Other Conditions — Duration ___

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank A Saunders M. D.
Address 1029 N. Stricker St. Date signed 10-13-44

G21637

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21637 Registered No. 1310

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1016 E Hoffman St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1016 E Hoffman St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George L. Heilman

3 (b) If veteran, name war No
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Rosalia Schmidt
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2 1869

8. AGE: Years 75 | Months 5 | Days 11 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Elevator Operator
11. Industry or business

FATHER
12. Name Frederick Heilman
13. Birthplace Pa

MOTHER
14. Maiden Name Mary Elizabeth Emmert
15. Birthplace Pa

16 (a) Informant Mrs. Rosalia Heilman
(b) Address 1016 E. Hoffman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 17 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location 4436 Belair Rd.

18 (a) Funeral director Calvary W. Coughlin & Son
(b) Address 924 E. Eager St.

19 (a) Date received by Registrar OCT 16 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13, 1944 at 9:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/21 1944 to 10/13 1944, and that I last saw h Alive on 10/7 1944

Immediate cause of death: Arteriosclerotic Cardio vascular renal disease — Duration 1

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Joseph S. Blum M.D.
Address 806 E. Preston St. Date signed 10/14/44

G21638

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131B

Registered No. G21638

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 Abbot St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d

(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Abbot St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Lewis
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bennie
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 11, 1892
8. AGE: Years 52 51 | Months 10 | Days 2 | If less than one day hr. min.
9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Charlie Foster
13. Birthplace N. C.

MOTHER
14. Maiden Name Nancy Williams
15. Birthplace N. C.

16 (a) Informant Bennie Lewis
(b) Address 1630 Abbot St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 16, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Louisburg N. Carolina

18 (a) Funeral director Mrs. Robert A Elliott & Son
(b) Address 1129 N. Carolina Ave

1944 OCT 16 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 13 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Oct 13 1944, and that I last saw h[illegible] alive on Oct 13 1944.

Immediate cause of death: Chronic Pneumonia Contributed Nephritis (Uremia)
Due to
Due to
Other Conditions: Mitral Insufficiency
(Include pregnancy within 3 months of death)

Duration: 6 years / 6 Mon

Date of operation: none
Major findings of operations: none
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph J Young M. D.
Address 1429 E Monument Date signed Oct 16/44

Dr Grimmer 2858 Harford Rd

G21639

G21639

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 480

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Englewood Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Englewood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Viola Gremer Bauereis

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	Married

6 (b) Name of husband or wife: E. Fred
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) April 6, 1889

8. AGE: Years	Months	Days	If less than one day
55	6	9	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William G. Lemmert
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Annie Glaser
15. Birthplace Baltimore Md

16 (a) Informant E. Fred Bauereis
(b) Address 2704 Englewood

17 (a) Burial (b) Date thereof Oct 19 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Baltimore Md

18 (a) Funeral director Wm Cook Mag
(b) Address Baltimore Md

OCT 16 1944
(c) (Date rec'd by Registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1944, at 6:03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944, to Oct 15 1944, and that I last saw h[illegible] alive on Oct 15 1944.

Immediate cause of death Cancer of uterus — Duration 2 yrs

Due to —

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fred Grimmer M. D.
Address 2858 Harford Date signed 10/16/44

VS 150

LIND

G21640

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G21640

Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Edison Rd
(c) Hospital or institution: Ashburton Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2030 N Wolfe St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Lind

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 9, 1865

8. AGE: Years 79 | Months 5 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)
10. Usual Occupation Retired Watchman
11. Industry or business P.O. R.R.

FATHER
12. Name Simon Lind
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Stantz
15. Birthplace Germany

16 (a) Informant Edw V. McLain
(b) Address 2030 N. Wolfe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Milton Kirk Dyer
(b) Address 1217 E Fort Ave

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Huntington Willard Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1944; at 3:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 14 1944, and that I last saw him alive on Oct 14 1944.

Immediate cause of death	Duration
Broncho Pneumonia	3d
Due to Arterio Sclerosis	14d
Hypertension	14d
Due to	
Other Conditions Chr Interstitial Nephritis	14 Yrs

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature F F O'Steen M. D.
Address 2878 Harford Rd Date signed 10/16/44

G21641

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G21641 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette and Calhoun
(c) Hospital or institution: Franklin Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County ~~~
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2615 Calvert St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Shaunessy (Catherine Shaunessy)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------

6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) --------- 1874

8. AGE: Years	Months	Days	If less than one day
70	---	---	-- hr. --- min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business None

FATHER
12. Name James Shaunessy
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Lynch
15. Birthplace Ireland

16 (a) Informant William Apsley
(b) Address 2817 North Calvert ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date received by registrar) (b) Emmitt Fox Williams, M.D. Registrar

OCT 18 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16th 1944, at 4A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-13-1944, to 10-15-1944 and that I last saw h[illegible] alive on 10-15-1944

Immediate cause of death Congestion
Heart Failure

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Fowler M.D.
Address 1317 Linden Ave Date signed 10/16/1944

G21642 BALTIMORE CITY HEALTH DEPARTMENT G21642
Registered No.

CERTIFICATE OF DEATH 93a

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 16 E. Randall St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 16 E. Randall St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick W. Eberlein

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Theresa A. Eberlein
6 (c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) May 11, 1872

8. AGE: Years 72 | Months 5 | Days 4 | If less than one day: hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Baker
11. Industry or business Gnd Biscuit Co

FATHER
12. Name Conrad Eberlein
13. Birthplace Pa.

MOTHER
14. Maiden Name Dont know
15. Birthplace Germany

16 (a) Informant Theresa A. Eberlein
(b) Address 16 E. Randall

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 18, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto City

18 (a) Funeral director G. Bernard Evans
(b) Address 1405 S. Carrollton

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1944, at 1145 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 8 1944 to Oct 15 1944, and that I last saw h[illegible] alive on Oct 14 1944.

Immediate cause of death — Acute Myocarditis — Duration 1 wks

Due to Asthma — 10 yrs

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G. B. Wells M. D.
Address 1279 Hillman Ct Date signed 10/15/44

G21643

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21643

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: D of A. Johns Hop Kins Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6000 Cedonia Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Clark

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business Box tender

FATHER 12. Name Charles Clark

13. Birthplace Maryland

MOTHER 14. Maiden Name Louise McCleave

15. Birthplace Maryland

16 (a) Informant Raymond Clark

(b) Address 1711 Gunfod Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-1944 (month) (day) (year)

(c) Cemetery or crematory Parkwood Cemetery

Location —

18 (a) Funeral director Mary M Wiedefeld

(b) Address 501 E. 32nd St

19 (a) OCT 16 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/44 19 , at 5:00 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B McCallop M.D. Medical Examiner.

Date signed 10/15/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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G21644

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21644 Registered No. 46 B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1913 N.Monroe Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1913 N.Monroe St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa M.Mc Garry

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) October 27, 1868

8. AGE: Years 75 | Months 11 | Days 18 | If less than one day ###### min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Thomas Mc Garry
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Sweeney
15. Birthplace Baltimore Md.

16 (a) Informant Mrs.Mary Thomas (Sister)
(b) Address 1913 N.Monroe

17 (a) Burial (b) Date thereof 10/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Avenue

18 (a) Funeral director George J.Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) Huntington Williams Mortuary OCT 16 1944 Received

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1944 at 6P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-10 1942 to 10/15 1944 and that I last saw h[illegible] alive on 10/15 1944.

Immediate cause of death: Bronchopneumonia — Duration 3d

Due to: Generalized Arteriosclerosis — Duration 2yr

Due to: Convulsions of Stomach

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph H Lawrence M. D.
Address 619 Warrington Blvd Date signed 10/16/44

G21645

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

52B

G21645 Registered No.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4. Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) abt. 2 yrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED
(a) State Md. (b) County Baltimore City 10
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4012 Dorchester Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Katherine Carroll
3 (b) If veteran, name war None
3 (c) Social Security Account No. None
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12-31-83
8. AGE: Years 60 Months 9 Days 14 If less than one day hr. min.
9. Birthplace Md - Balto. City (Town, county, and state)
10. Usual Occupation Retired teacher
11. Industry or business WRONG

FATHER
12. Name Thomas Heenick
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary E. Quem
15. Birthplace Balto., Md.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct-17-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore
18 (a) Funeral director Sturdivant Mowen Co.
(b) Address 108 W North Ave.
19 (a) Date received OCT 16 1944 (b) Registrar Hattie for Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1944 at 9 40 M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 15 1944 to Oct 14 1944 and that I last saw her alive on Oct 14 1944

Immediate cause of death carcinoma of the bladder — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation biopsy 2-17-43

Major findings of operation infiltrating carcinoma of bladder

of autopsy none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Josephine E. Ramsburg M. D.
Address Johns Hopkins Hospital Date signed 10/14/44

G21646 G21646

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1600 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 W. Bare St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 W Bare St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arnold Lee Jones

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 12, 44

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Moses Jones
13. Birthplace Summerton, S.C.

MOTHER 14. Maiden Name Lila House
15. Birthplace Summerton, S.C.

16 (a) Informant Lila Jones
(b) Address 415 W. Bare St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 16 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 16 1944 (Date rec'd by registrar) (b) Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1944 to Oct. 15 1944, and that I last saw him alive on Oct. 14 1944.

Immediate cause of death	Duration
Respiratory Failure	
Due to Intracranial Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
Address Univ. Hosp. Date signed 10/17/44

2239

G21647 O'Hayer G21647

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Ave.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2712 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. O'Hayer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Mary A.

6 (c) If single, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18-1875

8. AGE: Years 68 | Months 9 10 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Timothy A. Hayer
13. Birthplace Maryland

MOTHER 14. Maiden Name Bridget McGrath
15. Birthplace Ireland.

16 (a) Informant
(b) Address St. Agnes Hos.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-44 (month) (day) (year)

(c) Cemetery or crematory Mon. Bath.
Location Old Frederick Rd.

18 (a) Funeral director John J. Mahon
(b) Address 4201 Greenmount Ave

OCT 16 1944 (Date received by registrar) (Huntington Williams M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1944, at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1944, to 10-14 1944, and that I last saw h[illegible] alive on 10/14 1944.

Immediate cause of death Cardiac Failure — Duration

Due to Carcinoma of Prostate

Due to

Other Conditions Thrombocytopenia Purpura

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Carcinoma prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W. Steer M. D.
Address St agnes Hosp. Date signed 10-14-44

G21648 HEALTH DEPARTMENT—CITY OF BALTIMORE G21648

CERTIFICATE OF DEATH √ 93D

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Hanbert St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. If of foreign birth? 30 yrs. mos. ds.

2. FULL NAME Mary Rurka √4

If U.S. Veteran specify WAR

(a) Residence: No. 1424 Hanbert St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
F	W	married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Michael Rurka

6. DATE OF BIRTH (month, day, year) aug 15 1874

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	1	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. House wife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Zygfan Pacholawicz

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Mr. Michael Rurka
(Address) 1424 Hanbert Street

18. BURIAL, CREMATION, OR REMOVAL Holy Cross A.A.Co.
Place Burial Date Oct 17 1944

19. UNDERTAKER John M. Weber
(Address) 401 S. Chester St

FILED OCT 16 1944 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 14, 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct. 3d, 1944 to 10/14/ 1944

I last saw her alive on 10/13/ 1944. Death is said to have occurred on the date stated above, at 7 A m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary thrombosis	11 days
Other contributory causes of importance: Hypertensive cardio vascular disease.	?

Was an operation performed? no Date of -- - -

For what disease or injury? - - -

What test confirmed diagnosis? D.f. Was there an autopsy? no

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
no If so, specify -- - -

(Signed) Harry Deibel M. D.

(Address) 1226 Hanover St.

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Entries information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G21649

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21649 Registered No. 1270

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E Monument St
(c) Hospital or institution: Sinai Hospital of Balto
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore City, (If outside city or town limits, write RURAL and give town)
(d) Street No. 4600 Pall Mall Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Winfred Coughlin
3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	single

6 (b) Name of husband or wife --
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1874

8. AGE: Years	Months	Days	If less than one day
70	9	1	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Maid
11. Industry or business Doctors Office & Home

FATHER
12. Name John Coughlin,
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Cuddy,
15. Birthplace Ireland

16 (a) Informant Mrs. Peter J. Coughlin,
(b) Address 4600 Pall Mall Road,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/16/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore City,

18 (a) Funeral director A. Vernon Lemmon.
(b) Address 4611 Park Heights Ave.

19 (a) Filed 1944 (b) Registrar Huntington Williams, M.D. Registrar

VS 189

MEDICAL CERTIFICATION

P.M.

20. DATE OF DEATH 10/13 1944, at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1944, to 10/13 1944, and that I last saw h.e. alive on 10/13 19 44

Immediate cause of death	Duration
Myocardial insufficiency	
Due to Pulmonary Edema	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10/10 44

Major findings of operation

Acute Tuberculosis

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dr. J. M. Greenberg
Address Sinai Hosp. Date signed 10/13/44 M.

G21650

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1700

G21650
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the... the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Essex
(If outside city or town limits, write RURAL and give town)
(d) Street No. # 6 Eastern Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ina M. Reed

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Arlee Reed
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apl. 28-1903

8. AGE: Years	Months	Days	If less than one day
41	5	17	hr. min.

9. Birthplace W. Va.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Bemis Bro. Bag Co.

FATHER
12. Name William Reel
13. Birthplace W. Va.

MOTHER
14. Maiden Name Clara Shirk
15. Birthplace W. Va.

16 (a) Informant Minnie Pennington
(b) Address (Buckeye) Back River Bridge

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-44 (month) (day) (year)
(c) Cemetery or crematory
Location Cumberland, Md.

18 (a) Funeral director John G. Connelly
(b) Address 418 Eastern Ave. Essex

19. (a) OCT 16 1944 (Date rec'd by registrar) (b) Thurlow Pottenger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1944, at 11:22 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractures of Skull.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 15 1944 11:55 P. Baker
(b) Where did injury occur? Eastern Ave & Back River Bridge
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by Auto

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed October 17, 1944

X3-151
OCT 16 1944

G21651

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √166

G21651 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 423 N Central Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Davis

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1920

8. AGE: Years	Months	Days	If less than one day
24			hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation —

11. Industry or business

FATHER 12. Name John Davis

13. Birthplace Va

MOTHER 14. Maiden Name Laura Bailey

15. Birthplace Va

16 (a) Informant J. E. Price

(b) Address Richmond, Va

17 (a) Burial (b) Date thereof 10 17 44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Richmond

Location Richmond, Va

18 (a) Funeral director Reg. D. Kelso

(b) Address 1303 Pressman St

19 (a) 1 6 1944 (b) Huntington Williams, M.D.
(Date) received by registrar Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15- 1944, at 12 20 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of brain

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-15- at 12.20 A M.
(b) Where did injury occur? Central Ave. & Orleans St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Fire-arm - revolver
(e) Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-15-44

G21652

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G21652

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 100 S. Smallwood St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) Country
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 S. Smallwood Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Lanehart

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-16-6359

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dora Lanehart

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) September 28, 1864

8. AGE: Years 79 | Months — | Days 17 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Hostler

11. Industry or business F. Burkart Mfg. Co.

FATHER
12. Name William Lanehart
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Schaefer
15. Birthplace Baltimore Md.

16 (a) Informant Charles F. Willey
(b) Address 200 S. Smallwood St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto., Maryland

18 (a) Funeral director George W. Lehnert
(b) Address 2101 Frederick Avenue

19 OCT 17 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1944 at 5a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1944 to Oct 15 1944
and that I last saw h m alive on Oct 14 1944

Immediate cause of death	Duration
Pulmonary Oedema	five hrs
Due to Myocarditis	2 wks
Due to Arteriosclerosis	2 yr
Other Conditions ✓	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations ✓
of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? ✓
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ While at work?
(Specify type of place) ✓
(e) Means of injury

23. Signature Howard Kelly M.D.
Address 707 W. Pratt St. Date signed 10/16/44

G21653

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 144a

Registered No. G21653

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Ramsay & Dukeland
(c) Hospital or institution: West Balto Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3W
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1925 Ramsay St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Ruth Parks (Eva Ruth Parks) G11271

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	W	M

6 (b) Name of husband or wife Edgar M. Parks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/20/1916

8. AGE: Years	Months	Days	If less than one day
28	8	25	hr. min.

9. Birthplace Balto Maryland (Town, county, and state)
10. Usual Occupation H, W
11. Industry or business Housewife

FATHER
12. Name John George [illegible]
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Edna May Cole
15. Birthplace Baltimore Maryland

16 (a) Informant Edgar Mitchell Parks
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Maryland

18 (a) Funeral director Geo. W. Schubert
(b) Address 3101 Frederick Avenue

1944 OCT 17 (Date rec'd by Reg.-Trar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Oct 15 1944 and that I last saw her alive on Oct 15 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Eclampsia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sara M. Walker M.D.
Address Taylor and Eye Date signed 10/18/44

VS 150

21654

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21654 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 Marion Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Marion Street
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET C. SCHWAB

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1901

8. AGE: Years	Months	Days	If less than one day
43	6	17	hr. min.

9. Birthplace Anne Arundel County, Md.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Frank Schwab
13. Birthplace Maryland

MOTHER
14. Maiden Name Marie Gleason
15. Birthplace Ireland

16 (a) Informant Mrs. Marie Schwab
(b) Address 902 Marion Street

17 (a) Burial (b) Date thereof 10-19-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Anne Arundel County, Md.

18 (a) Funeral director Chas. H. Depkin
(b) Address 2101 Frederick Avenue

19 (a) 10 17 1944 Beatrice for Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1944, at 84 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1944, to Oct 16 1944
and that I last saw h alive on Oct 11 1944.

Immediate cause of death Cerebral hemorrhage

Due to Hypertension & Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M.D.
Address 502 Patapsco Ave Date signed 10/16/44

Dr Assist Radcliffe St Agnes Hospital ✓ G21655

G21655.

Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G21655

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1000 Catonsville
(c) Hospital or institution: Jenkins Memorial Hosp 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12yrs
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Barclay St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Catherine Kaiser

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 26th 1859

8. AGE: Years 85 | Months 8 | Days 20 | If less than one day hr. min.
1867 1 25

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Nicholas Kaiser
13. Birthplace Germany

MOTHER
14. Maiden Name Sophia Nordmeyer
15. Birthplace France

16 (a) Informant Mrs Laura Strinkamp
(b) Address 2528 Guilford Ave

17 (a) Burial (b) Date thereof 10/17/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Balto Md

18 (a) Funeral director William Cook Inc
(b) Address 1247 St. Paul St

19 (a) OCT 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15/1944 at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 6/1 1944 to 10/15 1944
and that I last saw h as alive on 10/14 1944

Immediate cause of death Cardiac Failure — Duration

Due to Chronic Myocardial Disease

Due to

Other Conditions Senile Chronic multiple arthritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address St Agnes Hosp. Date signed 10/15/44
M. D.

G21656 BALTIMORE CITY HEALTH DEPARTMENT G21656
CERTIFICATE OF DEATH 937
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4703 Greenhill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Greenhill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Isabella V. Phillips

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Harry L.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9 1884

8. AGE: Years	Months	Days	If less than one day
60	9	5	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER 12. Name Charles Whiteley
13. Birthplace Baltimore

MOTHER 14. Maiden Name Maria Muse
15. Birthplace ?

16 (a) Informant Mr. Harry L. Phillips
(b) Address 4703 Greenhill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem. Co.
Location Baltimore Md.

18 (a) Funeral director L. J. Rauch
(b) Address 5305 Harford Rd

19 OCT 17 1944 (b) (Date rec'd by Registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1944, at 12 noon M

21. I certify that death occurred on the date above stated; that I attended deceased from May 30, 1942, to Oct. 14, 1944, and that I last saw her alive on Oct. 14, 1944

Immediate cause of death	Duration
Broncho Pneumonia	3 days
Congestive Heart Failure	1 day
Due to Cerebral Hemorrhage	2 years.
	4 months
Due to Arteriosclerosis	Unknown
Chronic Myocarditis	Unknown
Other Conditions Bronchitis	1 month

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Philip Arrigoni M.D.
Address 2942 E. Fayette St. Date signed 10/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G21657

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

✓ G21657 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution:
Franklin Square Hosp. 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Springwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alfred J. Zang

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-09-3853

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Minnie Edelman Zang
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 22, 1888

8. AGE: Years	Months	Days	If less than one day
56	3	23	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Apt. house

FATHER
12. Name Frederick Zang
13. Birthplace Baltimore

MOTHER
14. Maiden Name Margaret Hayden
15. Birthplace Dames Quarters, Somerset Co. Md.

16 (a) Informant Mrs. A. J. Zang
(b) Address 4311 Springwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore, Md.

18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Bel Air Rd.

19 (a) OCT 17 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1944 at 8.30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 16 1944 to Oct 15 1944 and that I last saw him alive on Oct. 15 1944

Immediate cause of death	Duration
Coronary Thrombosis	2 mos
Due to Arteriosclerosis with Hypertension	Several yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. L. Wilkinson
A. L. Wilkinson, M. D.
Address 5713 Bel Air Rd. Date signed 10-17-44

G21658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G21658
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3819 Roland Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3819 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Daniel Heubeck

3 (b) If veteran, name war —

3 (c) Social Security Account No. 705-09-8069

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Elizabeth L. Heubeck

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 9-1880

8. AGE: Years 63 | Months 10 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Pattern Maker

11. Industry or business Baltimore & Ohio Railroad

FATHER 12. Name Henry D. Heubeck

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Mollie M. Demory

MOTHER 15. Birthplace Virginia

16 (a) Informant Mrs. Elizabeth L. Heubeck

(b) Address 3819 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-1944 (month) (day) (year)

(c) Cemetery or Crematory Mt. Moriah Lamsdale

Location Baltimore, Md.

18 (a) Funeral director Burgee Funeral Home

(b) Address 3631 Falls Road

19 (a) OCT 17 1944 (Date received by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15. 1944 at 11 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 14 1944 to Oct 15 1944 and that I last saw him alive on Oct 15 1944

Immediate cause of death: Cardio-renal Vascular Disease — Duration 15 mo

Due to: Coronary Thrombosis — 2 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J N Mcgee

Address 617 W. 40th Date signed 10/16/44 M.D.

VS 180

G21659

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

G21659 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in years, months, days, and hours. The cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1824 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME AARON MILLER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Rosa

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Louis Rumig
13. Birthplace

MOTHER
14. Maiden Name Mollie
15. Birthplace Rumig

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-17-44 (month) (day) (year)
(c) Cemetery or crematory Balto Hebrew
Location Baltimore Md

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) (Date received by registrar) (b) Registrar

OCT 17 1944

VS-100

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1944, at 12:10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1944, to 10/16 1944, and that I last saw h[illegible] alive on 10/16 1944.

Immediate cause of death Carcinomatosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation: none

of autopsy: Generalized Carcinoma

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature D. F. M. Kreuzburg M. D.
Address Sinai hospital Date signed 10/18/44

G21660

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1222 G21660

CA-39740

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 mo. 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1303 Cavendish Way (O'Donnell Heights)
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patrick Rodweller

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1944

8. AGE: Years	Months	Days	If less than one day
	8	5	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Alexander Rodweller
13. Birthplace New Jersey

MOTHER
14. Maiden Name Margaret Kennedy
15. Birthplace New Jersey

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial
(Burial, cremation, or removal)
(b) Date thereof 10/18/44
(month) (day) (year)
(c) Cemetery or crematory St Mary's
Location Irvington Md.

18 (a) Funeral director Wilhelm Lockard
(b) Address 1217 E Lombard St

19 (a) OCT 17 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-10 1944, to 10-15 1944, and that I last saw him alive on 10-14 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Recurrent Pneumonia	10-14 days
Due to	
Other Conditions Peritonitis	3 wks.

(Include pregnancy within 3 months of death)

Date of operation 8-10-44
Major findings of operation: Enteric Intussusception due to Meckel's Diverticulum.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R Fuller M. D.
Address Balt City Hosp Date signed 10-16-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. correct age is especially important. Physicians: please write

G21661

HEALTH DEPARTMENT—CITY OF BALTIMORE G21661

CERTIFICATE OF DEATH 94a

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 2237 E. Preston St., 4 Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

If U. S. Veteran specify WAR .....

2. FULL NAME Henry W. Wells

(a) Residence: No. 2237 E. Preston St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a. If married, widowed, or divorced HUSBAND of [first name] Charlotte Wells

6. DATE OF BIRTH (month, day, year) Nov 12th 1859

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
84	11	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Insurance Agent

10. Date deceased last worked at this occupation (month and year) .....

11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (city or town) Balto. (State or country) Md.

FATHER

13. NAME (Unknown) Wells

14. BIRTHPLACE (city or town) " (State or country)

MOTHER

15. MAIDEN NAME Bertha "

16. BIRTHPLACE (city or town) " (State or country)

17. INFORMANT Bertha Wells
(Address) 2237 E. Preston St

18. BURIAL, CREMATION, OR REMOVAL
Place Western Date Oct 18th 1944

19. UNDERTAKER William Cook Inc.
(Address) 217 St. Paul St

20. FILED OCT 17 1944 [illegible] for Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 16th 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct 10 1944 to Oct 16 1944

I last saw him alive on Oct 16 1944. Death is said to have occurred on the date stated above, at 2:30 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of Onset
Cerebral Thrombosis	10/9/44
Other contributory causes of importance: Nephritis & Uremia	1942

Was an operation performed? ..... Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19...

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) [illegible] M. D.

(Address) [illegible]

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

G21662 160 ✓ G21662

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 E

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 St. Paul St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Lorenca Igo

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Mar 24 1875

8. AGE: Years	Months	Days	If less than one day
69	6	22	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Michael Igo
13. Birthplace Dublin, Ireland

MOTHER
14. Maiden Name Mary E. Cross
15. Birthplace England

16 (a) Informant Clara V. Igo
(b) Address 1611 St. Paul St

17 (a) Burial (b) Date thereof 10/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

OCT 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 19 44, at 10:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 19 44, to 10/16 19 44, and that I last saw h.er alive on 10/16 19 44.

Immediate cause of death	Duration
Intestinal Obstruction	
Due to Carcinoma of Cecum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. Williams M. D.
Address 1100 W. Saratoga St Date signed 10/16/44

G21663

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G21663

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 W. Mulberry St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Helen E. Wilson

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: ~~Married~~ widow

6 (b) Name of husband ~~or wife~~ Boots Wilson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31st 1903

8. AGE: Years 41 | Months 2 | Days 15 | If less than one day hr. min.

9. Birthplace Balto. Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business At Home

FATHER — 12. Name Louis E. Welty
13. Birthplace Md

MOTHER — 14. Maiden Name Mattie B. Barrick
15. Birthplace Md.

16 (a) Informant Gertrude Welty
(b) Address 415 W. Mulberry St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory Balto Md.
Location

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 17 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1944, at 7.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1944, to October 16 1944, and that I last saw her alive on October 16, 1944

Immediate cause of death Carcinomatosis
Resp. Failure

Due to Metastasis Generalized
From Carcinoma of uterine cervix

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard Trabord Jr. M. D.
Address University Hospital Date signed 10/16/44

G21664

461012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21664

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 wks
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Except — (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 Mace Ave — (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bonnie Joan Otis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-12-44

8. AGE: Years | Months 5 | Days 3 | If less than one day ... hr. ... min.

9. Birthplace Md. — (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Otis
13. Birthplace W. Va. —

MOTHER
14. Maiden Name Doris Hamman
15. Birthplace Md. —

16 (a) Informant Records —
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10-17-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn Cemetery
Location Baltimore, Md.

18 (a) Funeral director Henry Sanders Sons Inc.
(b) Address North Ave. & Broadway — 13

OCT 17 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

55

20. DATE OF DEATH Oct. 16, 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1944 to Oct. 15 1944 and that I last saw he alive on Oct. 16 1944

Immediate cause of death	Duration
pneumonia	
Due to epithelial changes in trachea and bronchi and bronchus	
Due to resistance to ordinary contaminants of Naso-pharynx	
Other Conditions Cystic fibrosis of Pancreas (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C Gorsan Jr. M. D.
Address Date signed 10/16/44

G21665

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

✓ G21665
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5512 Gwynn Oak Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 W
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5512 Gwynn Oak Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ellen L. Northern

3 (b) If veteran, name war — — —

3 (c) Social Security Account No. — — —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Dr. Robert J. Northern

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1873

8. AGE: Years	Months	Days	If less than one day
71	8	20	hr. min.

9. Birthplace Adrian, Mich.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name George L. Gifford
13. Birthplace New York

MOTHER
14. Maiden Name Janie E. Vaile
15. Birthplace Adrian, Mich.

16 (a) Informant Dr. Robert J. Northern
(b) Address 5512 Gwynn Oak Ave.

17 (a) Burial (b) Date thereof Oct. 18, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory London Park
Location Baltimore, Maryland

18 (a) Funeral director William J. Tickner & Son
(b) Address North & Pennsylvania Ave.

19 (a) OCT 17 1944 (b)
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 19 44, at 11 A. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Cervix.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Jd. L. W. Wallenmeyer, M.D.
Medical Examiner.
Date signed October 16, 1944.

G21665

BALTIMORE CITY HEALTH DEPARTMENT G21666

CERTIFICATE OF DEATH 830

Registered No. 7678

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1307 Stockton St. 15th
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1307 Stockton St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Philip Martin Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	colored	married

6 (b) Name of husband or wife Gertrude Jackson
6 (c) If alive, give age . years

7. Birth date of deceased (mo., day, yr.) 11-22-1889

8. AGE: Years	Months	Days	If less than one day
54	11-10	22	..... hr. ..... min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation Labor
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Gertrude Jackson
(b) Address 1307 Stricker St.

17 (a) Burial (b) Date thereof 10-17-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pleasant Hert
Location Towson Md

18 (a) Funeral director Lloyd L. Nelson
(b) Address 1303 Presstman St

19 (a) (b)
(Signature of local registrar)

OCT 17 1944
VS 180

Huntington for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14 1944, at 9.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12-1944, to 10-14-1944, and that I last saw him alive on 10-13-1944.

Immediate cause of death Cerebral hemorrhage — Duration

Due to

Due to

Other Conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank A. Saunders M. D.
Address 102 N. Stricker St Date signed 10-16-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G21667

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G21667 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 417 Mosher St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 417 Mosher St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? — years

3 (a) FULL NAME Alease Hawkins

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Jessie Hawkins
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 17 - 1909

8. AGE: Years 35 | Months - | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation maid

11. Industry or business

FATHER
12. Name Arthur Sheppard
13. Birthplace md

MOTHER
14. Maiden Name Irene Wallace
15. Birthplace md

16 (a) Informant Executrix W. Christian
(b) Address 417 W. Mosher St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James Adams
(b) Address 1142 Woods St

19 (a) OCT 17 1944 (Date rec'd by registrar) by Harrington-Hillsville

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1944, at 11.25 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 3 1944, to Oct 16 1944, and that I last saw h[illegible] alive on Oct 12 1944.

	Duration
Immediate cause of death: Cancer of Rectum	3 mo
Due to: Cancer of Cervix	1 yr
Due to:	
Other Conditions: Colitis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Douglas Sheppard M. D.
Address 1431 W. Franklin St Date signed 10-16-44

G21658

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G21668 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1158 Hull St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Andrew Sharlofsky or Scharlawsky

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sophie Sharlofsky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not known

8. AGE: Years 64 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Fedor Sharlofsky
13. Birthplace Russia

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18-44 (month) (day) (year)
(c) Cemetery or crematory Holy Trinity Location Stony Run & E. Cold

18 (a) Funeral director Jno. A. Brettinacher Jr.
(b) Address 423 S. Paca St

19 (a) (Date rec'd by registrar) (b) Registrar

VS OCT 17 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1944 at 1.03 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Oct 14 1944; that I last saw him alive on Oct 14 1944

Immediate cause of death: Pulmonary failure — Duration:

Due to: Kidney tumor with metastasis

Due to:

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy: Anatomical Diag. 10/14/44

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Theo D Pruett
Address Johns Hopkins Hosp Date signed 10/14/44

C21669

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

C21669 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 431 South Ellwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 76

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 431 South Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edmund Zacharski

3 (b) If veteran, name war | 3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Julia
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) Sept, 13th 1866

8. AGE: Years	Months	Days	If less than one day
78	1	3	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Organist-Retired.
11. Industry or business

FATHER
12. Name Michael Zacharski
13. Birthplace Poland

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Casimir Zacharski Sr
(b) Address 427 South Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rozary
Location Baltimore Md
18 (a) Funeral director George A Weber
(b) Address 705 S Penn St
19 (a) OCT 17 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16th 1944, at 6.55 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1942 to Oct. 16 1944, and that I last saw h alive on Oct. 16 1944

	Duration
Immediate cause of death Myocardial Insufficiency	1 mth.
Due to Chronic Myocarditis	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature John V. Zacharski M. D.
Address 980 Eastern Ave Date signed 10-16-44

VS 150

G21670

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 56D

Registered No. G21670

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6001 BELONIA AVE.
(c) Hospital or institution:
EDGEWOOD NURSING HOME
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 9
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 EASTERN AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTINA KLENSKE

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife: RAYMOND KLENSKE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JAN. 21 1906

8. AGE: Years	Months	Days	If less than one day
38	8	25	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation HOUSE WIFE
11. Industry or business AT HOME

FATHER
12. Name JOHN SEITZ
13. Birthplace BALTO. MD.

MOTHER
14. Maiden Name ELIZABETH WEHNHOLD
15. Birthplace BALTO. MD.

16 (a) Informant RAYMOND KLENSKE (HUS)
(b) Address 4007 EASTERN AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 19/44 (month) (day) (year)
(c) Cemetery or crematory OAK LAWN CEM.
Location EASTERN AVE EXT.
18 (a) Funeral director Lilly & Gaither
(b) Address 403 S. WOLFE ST.
OCT 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH OCT. 16 1944, at 7/30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-18 1943, to 10-8 1944.
and that I last saw her alive on 10-8 1944.

Immediate cause of death: Brain Tumor — Duration 4 yrs
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 12-2-43 Dr. Dandy
Major findings of operation: Diagnostic Air Injection - Brain
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Hansemann M.D.
Address 1501 Eutaw Pl Date signed 10-16-44

C21671

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

Registered No. C21671

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special attention is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1103 S.BAYLIS ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 S.BAYLIS ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARIE BLUME

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: EDWARD BLUME
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV.27 1858

8. AGE: Years 85 | Months 10 | Days 18 | If less than one day hr. min.

9. Birthplace GERMANY (Town, county, and state)

10. Usual Occupation HOUSE WIFE

11. Industry or business AT HOME

FATHER
12. Name UNKNOWN
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant ANNIE MACK (FRIEND)
(b) Address 1113 S.BAYLIS ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT.18/44 (month) (day) (year)
(c) Cemetery or crematory SACRED HEART
Location GERMAN HILL ROAD

18 (a) Funeral director Lilly & Zeh Co.
(b) Address 403 S. WOLFE ST.

19 OCT 17 1944 (b) (Date rec'd by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

PM.

20. DATE OF DEATH OCT.15 1944 at 8/05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13 1944, to Oct. 15, 1944, and that I last saw h.e.r. alive on Oct. 11 1944.

Immediate cause of death: FAECAL IMPACTION. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Allen S. Peetham
Address 3134 E. Baltimore St. Date signed 10-16-44 M. D.

Huntington Williams, M.D.

Peetham

G21672

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No. G21672

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 129 McPhail St.
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 129 McPhail St. (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Theodore Langenfeldt

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Jennie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1866

8. AGE: Years 78 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation none - retired

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Elizabeth G. Lovett
(b) Address 208 E. Lake Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/17/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Bal North & Milton Aves.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) [illegible] (Date received by registrar) (b) [illegible] Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1944, at 12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 21 1944, to Oct 15 1944, and that I last saw h[illegible] alive on Oct. 12 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Infection Rt foot + leg. (Include pregnancy within 3 months of death)

Date of operation None.

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature George E. Glaeser M.D. M. D.
Address Medical Arts Bldg. Date signed 10/16/44

G21673

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G21673

Registered No.

10 489927

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4215 Ivanhoe Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Mildred Ziolkowski

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frank
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Sept. 13, 1908

8. AGE: Years: 36 Months: -1- Days: -2- If less than one day: hr. min.

9. Birthplace: Poland
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name: Anthony Skrzypya (d)
13. Birthplace: Poland

MOTHER
14. Maiden Name: Sophia Kufel
15. Birthplace: Poland

16 (a) Informant: Records, Baltimore City Hosp.
(b) Address: 4940 Eastern Avenue

17 (a) Burial (b) Date thereof: Oct 18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Holy Rosary
Location: Baltimore

18 (a) Funeral director: Fred W Ozazewski
(b) Address: 1930 Eastern Ave

19 (a) (b)
(Signature of registrar) (Address)

OCT 17 1944

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1944, at 3:38PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 23, 1944 to Oct. 15, 1944, and that I last saw her alive on Oct. 15, 1944.

	Duration
Immediate cause of death: Bronchopneumonia, tuberculosis ?	3 days
Due to: Pulmonary tuberculosis	?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation 10-2 9-10-44

Major findings of operation: Bronchogram Bronchiectasis + pulmon. T.B.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Hauck E. Belton M. D.
Address: Balt. City Hosp. Date signed 10/14/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21674

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21674 Registered No. 1318

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1337 N. Stricker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1337 N. Stricker St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Walker
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Reuben Walker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/3/1885

8. AGE: Years 58 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Hendrick, Va. (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Duncan Bailey
13. Birthplace Va.

MOTHER
14. Maiden Name Josephine Seward
15. Birthplace Va

16 (a) Informant Husband
(b) Address 1337 N. Stricker St

17 (a) (Burial, cremation, or removal) (b) Date thereof 10-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Baltimore Md.

18 (a) Funeral director Joseph P.A. Gehron Sr.
(b) Address 1135 Harwood Ave

19 (a) OCT 17 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 14 1944, at 6:17 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 21 1944 to Oct 14 1944 and that I last saw her alive on Oct 13 1944.

Immediate cause of death: Coma
Interval: 1 mo.
Due to: Chronic Nephritis
Interval: 1 day
Due to:
Other Conditions: None
(Includes pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 817 Hamilton Ter Date signed

G21675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

195c G21675

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Rutter St. 1 Ward)

Registered No.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Samuel Holley

If U. S. Veteran specify WAR

(a) Residence: No. 1504 Rutter St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	C	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Margaret Holley

6. DATE OF BIRTH (month, day, year) Apr. 2 1897

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6 5	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Laborer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Portsmouth Virginia

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Margaret Holley

(Address) 1504 Rutter St

18. BURIAL, CREMATION, OR REMOVAL

Place Cloverdale, Va. Date Oct. 17, 1944

19. UNDERTAKER Wm. Geo. H. Holland

(Address) 1831 Druid Hill Ave

20. FILED ..... 19.... Registrar.

OCT 17 1944

Huntington Printing Co., Inc.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct. 14, 1944

22. I HEREBY CERTIFY, That I attended deceased from June 2, 1944, to Oct. 14, 1944

I last saw him alive on Oct. 14, 1944. Death is said to have occurred on the date stated above, at 2:30 P m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Organic Heart Disease	
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Clin. Ex. Was there an autopsy? No

22. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury — 19....

Where did injury occur? —
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury —

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) R. Garland Shurtleff M. D.

(Address) 1534 Druid Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G21676

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

184

G21676

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Early Heights Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald E. Rensing
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male
5. Color or race White
6 (a) Single, married, widowed, or divorced. —
6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 23, 1941

8. AGE: Years 3 | Months 6 5 | Days 22 | If less than one day ____ hr. ____ min.

9. Birthplace A. A. County Md. (Town, county and state)

10. Usual Occupation —

11. Industry or business

FATHER
12. Name John A. Rensing
13. Birthplace Md.

MOTHER
14. Maiden Name Mildred Yonker
15. Birthplace Md.

16 (a) Informant John A Rensing
(b) Address Earlehaights Heights A.A.Co.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18th 1944 (month) (day) (year)
(c) Cemetery or crematory Cumphreys Gem
Location A. A. Co. Md.

18 (a) Funeral director Charles F. Dill
(b) Address 5701 Ft. Foot Ave

19 (a) OCT 17 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15- 1944, at 11 03 A.M.

21. I certify that I took charge of the remains described above, held an Inspection + Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Bullet wound of Heart

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-15- at 10.45 A.M.
(b) Where did injury occur? Early Heights, Pasadena
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? Playing
(d) Means of injury 22 Rifle

23. Signature Howard J. Moellers M.D.
Medical Examiner.
Date signed 10-15-44

G21677

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

107

G21677
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Maryland (b) County
(c) City or town Baltimore City
(If outside city or town, write rural district)
(d) Street No. York Rd. - Balto Co. 5 mi. (If rural give location)
(e) Citizen of foreign country? (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Sister Mary Celestine Doyle R.S.M.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Dec. 15-1865
8. AGE: Years 78 | Months 10 | Days 1 | If less than one day hr. min.
9. Birthplace Yonkers, New York. (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business Religious.

FATHER
12. Name Peter Doyle
13. Birthplace Ireland

MOTHER
14. Maiden Name Bridget Kiernan
15. Birthplace Ireland.

16 (a) Informant Sister M. Cyril R.S.M.
(b) Address St. Vincent's Male Orphanage
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt. St. Agnes Cemetery
Location Mt. Washington
18 (a) Funeral director H. W. Meamsdow
(b) Address 805 N. Calvert St.
19 (a) (Date received by registrar) OCT 17 1944 Huntington Hill

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1944 at 8 28 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1944, to Oct 16 1944, and that I last saw her alive on Oct 16 1944.

	Duration
Immediate cause of death: Cardio-Resp failure	
Due to: Pneumonia	1 week.
Due to:	
Other Conditions:	over

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Charles F. O'Donnell M.D.
Address Mercy Hosp. Date signed 10/16/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G21678 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 346 S. Bouldin St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 76
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 346 S. Bouldin St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY C. GREEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
-----	-------

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed.

6 (b) Name of husband or wife Thomas Green
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 26, 1856.

8. AGE: Years	Months	Days	If less than one day
87	10	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business At home.

FATHER
12. Name George Momberger
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany

16 (a) Informant Mrs. Marg. Mertel (Daughter)
(b) Address 346 S. Bouldin St.

17 (a) Burial (b) Date thereof 10/18/44.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Annapolis Rd. Md.

18 (a) Funeral director Charles L. Zeiler
(b) Address 3605 Fait Ave.

19 (a) OCT 17 1944 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1944, at 11:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1944 to Oct. 15 1944 and that I last saw h[illegible] alive on Oct. 15 1944

Immediate cause of death Myocardial Insufficiency — Duration 3 days
Due to Cerebral Arteriosclerosis — ?
Due to
Other Conditions Chr. Endocarditis ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isaac J. Temple
Address 7002 E. Fait Ave. Date signed 10/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-1679 Dup. 2-21679

AB-90071

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 108

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore City Hospitals
(c) Hospital or institution: Baltimore City Hospitals 6
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13days
(e) Length of stay in Baltimore (yrs., mos., or days) Life 2 mos 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 406 N. Regester St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8-1944

8. AGE: Years | Months 5 | Days 8 | If less than one day hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Walker
13. Birthplace Va.

MOTHER
14. Maiden Name Pearl Walker
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County Md.

18 (a) Funeral director Mrs Robert A. Elliott & Son
(b) Address 1129 N. Caroline St.

19 OCT 17 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-16 1944, at 9.50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-3 1944 to 10-16-1944 and that I last saw him alive on 10-16-1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Pulmonary	10 days
Due to	
Other Conditions	over

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ellis Feer

Address Baltimore City Hosp. Date signed M. 10 D. 16-44

G21680 BALTIMORE CITY HEALTH DEPARTMENT G21680
CERTIFICATE OF DEATH 113 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 720 Bay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 64

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 720 Bay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country –

3 (a) FULL NAME Walter J Johnson
3 (b) If veteran, name war –
3 (c) Social Security Account No. 219-01-8060

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Jessie A.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 1866
8. AGE: Years 77 | Months 11 | Days 18 | If less than one day 12 hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation Retired Textile worker
11. Industry or business Cotton duck mill

FATHER
12. Name Richard Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Mary Norris MORRIS
15. Birthplace Va

16 (a) Informant Mrs Jessie A Johnson
(b) Address 720 Bay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 19-44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Md
18 (a) Funeral director Frank W Ertz
(b) Address 814 N. 36 St

19 (a) (b) Registrar

OCT 17 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1944, at 1.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Sept 1944, and that I last saw him alive on Sept 28 1944

Immediate cause of death Acute Pulmonary Edema — Duration 2 days

Due to Chronic Pulmonary Emphysema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Simeon V. F. Markline M. D.
Address 910 W. 37 St Date signed 10-16-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21681

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21681 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 911 Mt. Holly St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 911 Mt. Holly Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Dueaberry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Agnes M. Dueaberry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 20, 1893

8. AGE: Years	Months	Days	If less than one day
51	2	25	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Dueaberry
13. Birthplace Va.

MOTHER
14. Maiden Name —
15. Birthplace Va.

16 (a) Informant Mrs. Agnes Dueaberry
(b) Address 911 Mt. Holly St.

17 (a) Burial (b) Date thereof 10-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director F. B. Hippert & Son
(b) Address 1300 Eutaw Place

19 (a) OCT 17 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION 10:20

20. DATE OF DEATH Oct. 15, 1944, at P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. T. Wallenmeyer M.D.
Medical Examiner.
Date signed Oct. 16, 1944

VS 151

M. D. B. 1936-9

C21682 **HEALTH DEPARTMENT—CITY OF BALTIMORE** C21682

CERTIFICATE OF DEATH 117a

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 1065 W. Lexington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME William E. Winn

(a) Residence: No. 1065 W. Lexington St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	Col	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Maze Winn

6. DATE OF BIRTH (month, day, year): June 18, 1890

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54	3	25	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Va

FATHER

13. NAME: Robert Winn

14. BIRTHPLACE (city or town) (State or country): Virginia

MOTHER

15. MAIDEN NAME: Polly Jones

16. BIRTHPLACE (city or town) (State or country): Virginia

17. INFORMANT: Ledonia Harris

(Address) 1065 W. Lexington St.

18. BURIAL, CREMATION, OR REMOVAL

Place: National Cemetery Oct 18, 19 44

19. UNDERTAKER: Mrs Katie R. Williams

(Address) 322 N. Fremont Ave

OCT 17 1944 19 Huntington Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Oct. 13, 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1942, to Oct. 13, 1944

I last saw him alive on Oct 12, 1944 Death is said to have occurred on the date stated above, at 5:10 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Ruptured Gastric Ulcer	3 days
Other contributory causes of importance: Gastric Ulcer	2 yrs

Name of operation ... Date of ...

What test confirmed diagnosis? Clinical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? ... If so, specify ...

(Signed) W. Donald Bando M. D.

(Address) 2445 Druid Hill Ave., Balto 17

N. B.—WRITE PLAINLY, ... WITH UNFADING INK—THIS ... PERMANENT RECORD. Every item ... information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G21683

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21683 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 M
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 514 S Oldham St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Kanpouris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1891

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unk.

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Hosp. Record.
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Oct 19-44 (month) (day) (year)
(c) Cemetery or crematory Greenlawn Cathedral Cem.
Location

18 (a) Funeral director Dr Francis Rene
(b) Address Westminster Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1944 at 6:20 A M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Featherson M.D.
Medical Examiner.
Date signed October 17, 1944

G21684

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21684

G21684 46 B

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Catalpha Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 Catalpha (If rural give location)
(e) Citizen of foreign country? Yes. (Yes or No)
If yes, name country Japan

3 (a) **FULL NAME** Inui, Fuji Taro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race Japanese

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Tazo Inui

6 (c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) April 7 1874

8. AGE: Years 70 Months 7 Days 10 If less than one day hr. min.

9. Birthplace Japan (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Toyemon Adachi
13. Birthplace Japan

MOTHER
14. Maiden Name Hatsu Adachi
15. Birthplace Japan

16 (a) Informant Mrs. G. D. Inui
(b) Address 4700 Catalpha Road

17 (a) Cremation (b) Date thereof Oct 19 44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore, Md.

18 (a) Funeral director D. D. Covington
(b) Address 21 N. 25 St.

19 OCT 17 1944 (b) Huntington, West Virginia (Date received by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1944 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from March 10 1944 to Oct 19 1944 and that I last saw h.. alive on Oct 10 19 44.

Immediate cause of death Carcinoma of Stomach — Duration 6 mos

Due to

Due to

Other Conditions

(Include prerogatory within 3 months of death)
Date of operation March 16, 1944
Major findings of operation: Carcinoma Stomach & metastases
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Speed M. Dean M. D.
Address Johns Hopkins Hosp Date signed Oct 19, 1944

G21685

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 168

G21685 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3804 Menlo Drive – Servant
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Letitia Bailey

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/26/1917

8. AGE: Years 26 | Months 10 | Days 17 | If less than one day ... hr. ... min.

9. Birthplace R. I.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Harry Lewis
13. Birthplace Mass

MOTHER
14. Maiden Name Fannie Yancey
15. Birthplace Va.

16 (a) Informant Fanny Lewis
(b) Address 49 Sterena St.

17 (a) Burial (b) Date thereof 10/14/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Lyndenwood
Location Stonehan Mass

18 (a) Funeral director George G. Kelly
(b) Address 1303 Pridestman St.

19 (a) OCT 17 1944 (b) Huntington Williams
(Entered by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14- 1944, at 11 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions Fractured wrist, laceration & bruised brain. Fractured rib.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-14- at 10.40 P.M.
(b) Where did injury occur? 1324 McCulloh St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Male struggling fractured through window

23. Signature Howard J. McLean M.D.
Medical Examiner.

Date signed 10-15-44

G21686

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G21686

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 N. Payson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 N. Payson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Roeder

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of ~~husband~~ wife Rosa Roeder

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 5th 1861

8. AGE: Years	Months	Days	If less than one day
83	0	11 12	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Hartman Roeder
13. Birthplace Germany

MOTHER
14. Maiden Name Barbara Dichelberger
15. Birthplace Paris, France

16 (a) Informant Berenice Roeder
(b) Address 901 N. Payson St.

17 (a) Burial (b) Date thereof 10/20/44
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ New Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook Sec.
(b) Address 627 St. Paul St.

19 (a) [illegible] (b) [illegible]
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1944 at 1 30 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic
Cardio Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Le Gratton M.D.
Medical Examiner.
Date signed Oct. 17 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21687

HEALTH DEPARTMENT—CITY OF BALTIMORE G21687

CERTIFICATE OF DEATH

1. PLACE OF DEATH Edgewood Nursing Home

CITY OF BALTIMORE: (No. 6000 Bellona Ave Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Florence C Price

If U. S. Veteran specify WAR

(a) Residence: No. 107 La Plaix Lane - Towson Md. Ward. Baltimore Co.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): Widowed

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of: Elijah M. Price

6. DATE OF BIRTH (month, day, year): May 5th 1868

7. AGE: Years: 76 Months: 5 Days: 12 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: At Home

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.: Self

10. Date deceased last worked at this occupation (month and year): ...

11. Total time (years) spent in this occupation: ...

12. BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

FATHER

13. NAME: Elijah Chilcoat

14. BIRTHPLACE (city or town) (State or country): Md

MOTHER

15. MAIDEN NAME: Mary Jane Pearce

16. BIRTHPLACE (city or town) (State or country): Balto. Co. Md.

17. INFORMANT: Mrs Carrol Cole

(Address) Colgrove Parkton Md.

18. BURIAL, CREMATION OR REMOVAL

Place: Forest Balto Co. Md. 10/20 1944

19. UNDERTAKER: William Cook Inc

(Address) 1219 St. Paul St.

FILED OCT 18 1944 ... for Williams Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Oct 17 1944

22. I HEREBY CERTIFY, That I attended deceased from June 1944 to Oct 17, 1944.

I last saw her alive on Oct 17 1944 Death is said to have occurred on the date stated above, at 5 PM p.m.

The principal cause of death and related causes of importance were as follows:

	Interval between onset and death
Carcinoma left breast	1941
Cmetastasis general, especially chest and abdomen.	

Other contributory causes of importance:

Pneumania, hypostatic	10/13/1944

Was an operation performed? Yes Date of 1941

For what disease or injury? Carcinoma left breast.

Name of operation Remove left breast.

What test confirmed diagnosis? Laboratory Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? No If so, specify ...

(Signed) Rollin C. Hudson M. D.

(Address) Towson, Md.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 3

C21688

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46D

Registered No. C21688

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 E. Lexington St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1106 E. Lexington St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Mc Garland

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F.

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25 1876

8. AGE: Years 68 | Months 1 | Days 20 | If less than one day hr. min.

9. Birthplace South Carolina. (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant ?
(b) Address 1106 Lexington st

17 (a) (Burial, cremation, or removal) (b) Date thereof 10 19 44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. J. Halstead
(b) Address 916 Druid Hill Ave.

19 (a) 10 1944 (Date received by registrar) (b) Lemuel Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15 1944, at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1944 to Oct 1944 and that I last saw h[illegible] alive on Oct 14 1944.

Immediate cause of death

	Duration
Carcinoma Bladder	1 mo
Due to Retention	8 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. J. Halstead

Address 1725 Pine Ave. Date signed 10/17/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21689

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937 ✓

Registered No. G21689

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 413 Robert St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 413 Robert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Adelaide Stumpe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race C

6 (a) Single, married, widowed or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 77 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Unknown

11. Industry or business

FATHER
12. Name
13. Birthplace unknown

MOTHER
14. Maiden Name
15. Birthplace unknown.

16 (a) Informant Mrs. Butler
(b) Address 413 Robert Street

17 (a) (Burial, cremation, or removal) (b) Date thereof 9-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 919 Druid Hill Ave

19 (a) OCT 18 1944 (Date rec'd by registrar) (Huntington Williams, M.D. Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/14 1944, at 9.30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular disease

Due to

Other Conditions Varicose ulcers lower extremities
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNulty Medical Examiner.
Date signed 10/16/44

G21690 ✓ G21690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55 B

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2807 Matthews st
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2807 Matthews st
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Alice Lorna Byer

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Leroy H. Byer
6 (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Dec 23 1900

8. AGE: Years 43 | Months 9 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business Home

FATHER
12. Name Edward Inflatt
13. Birthplace Talbot Co Md.

MOTHER
14. Maiden Name Sarah R. Kean
15. Birthplace Brunswick Md

16 (a) Informant Mrs Mary Hastings
(b) Address 8008 Douglas Ave

17 (a) Burial (b) Date thereof Oct 20-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Eastern Dare
(b) Address 2324 E Eastern Ave

19 OCT 18 1944 (Date rec'd by registrar) Huntington Hillsboro, Md (Registrar)

V8 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1944, at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 24 1944, to Oct 17 1944, and that I last saw h[er] alive on Oct 16 1944.

Immediate cause of death	Duration
Carcoma of Rt. Hip	
Due to Metastatic Carcoma of Spine	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Samuel D. Little M. D.
Address 1331 E. North Ave Date signed 10-19-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21691

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G21691

G21691

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 Harlem ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 Harlem ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ~~Boy~~ Harlem Ollie Morris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race colored

6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 9, 1944

8. AGE: Years | Months 4 | Days 7 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Infant

11. Industry or business

FATHER
12. Name James O. Morris
13. Birthplace Va

MOTHER
14. Maiden Name Pauline Morris
15. Birthplace Va

16 (a) Informant James O Morris
(b) Address 1308 Harlem ave

17 (a) Burial (b) Date thereof 10-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director George G. Nelson
(b) Address 1844 Pennsylvania Ave

19 (a) OCT 18 1944 (b) Huntington Willis Borden, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1944, at 3 20/ M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1944 to 10/16 1944, and that I last saw him alive on 10/16 1944.

Immediate cause of death Bronchopneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hunt Boutte M. D.

Address 2134 Druid Hill Date signed

G21692
461339

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

30 ✓

G21692

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 D.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 868 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Leona B. Reid (Johnson)
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-27-03
8. AGE: Years 40 | Months 11 | Days 20 | If less than one day hr. min.
9. Birthplace Mich. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER 12. Name Charles Edward Johnson
FATHER 13. Birthplace Mich.
MOTHER 14. Maiden Name Nora Steven
MOTHER 15. Birthplace N.Y.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct. 20/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Detroit Mich
Location
18 (a) Funeral director John O. Mitchell Sons
(b) Address 1900 Eutaw Place

19 (a) Date rec'd by registrar OCT 18 1944 (b) Registrar Huntington Williams, M.D.
VS 1-50

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1944 at 4.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1944, to Oct. 17 1944, and that I last saw h[illegible] alive on Oct. 17 1944.

Immediate cause of death Cardiac failure — Duration 9 weeks
Due to Syphilitic heart disease & syphilitic aortic regurgitation.
Due to
Other Conditions ? Old TB - ? Myocardial infarction
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Bencin M. D.
Address J. Hopkins Hosp. Date signed 10-17-44

G21693 ✓ G21693

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

108 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 309 S. Sharpe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. Whittington

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace a a co md (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name James Whittington
13. Birthplace Md

MOTHER
14. Maiden Name Maria Weaver
15. Birthplace Md

16 (a) Informant Frances Randall
(b) Address 911 West St Annapolis Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location a a co Md

18 (a) Funeral director Isaiah T. Brannon
(b) Address 108 N Montgomery St

19 (a) OCT 18 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 15, 1944, at 3:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia, lobar, bilateral

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed Oct. 16, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21694 ✓ G21694 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1135 Myrtle ave
(c) Hospital or institution: 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 75 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 1135 Myrtle ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eliza Ann Thomas
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-9-1856

8. AGE: Years	Months	Days	If less than one day
88	2	6	hr. min.

9. Birthplace Easton Md (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name Zadariah Small
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ann ?
15. Birthplace Md

16 (a) Informant Miss Maggie Lee
(b) Address 1135 Myrtle ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem-
Location A. A. County Md

18 (a) Funeral director Allegra A Jackson
(b) Address 916 Emma ave

19 (a) (Date rec'd by registrar) (b) By registrar

vs OCT 18 1944 Huntington Mitchell

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15 1944 at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1944 to 10/15 1944 and that I last saw h alive on 10/14/1944

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to Paralysis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Hortense Cowl M. D.
Address 1163 Harlem Ave Date signed 10/14/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Aug G21685 amit

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

Registered No. G21695

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution:
UNION MEMORIAL HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 50 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3303 GUILFORD AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. MARION M. BOYLE

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEMALE	WHITE	WIDOWED

6 (b) Name of husband ~~or wife~~ JAMES D. BOYLE (d)
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 3, 1883

8. AGE: Years	Months	Days	If less than one day
61	9	13	— hr. — min.

9. Birthplace West Chester PENNSYLVANIA.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business HOUSEKEEPER

FATHER
12. Name JOHN R. MAGUIRE
13. Birthplace PENNA. (Phila.)

MOTHER
14. Maiden Name MARY J. FOLEY
15. Birthplace PENNA. (Phila.)

16 (a) Informant PATIENT
(b) Address —

17 (a) Burial (b) Date thereof 10/19/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) OCT 18 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 16, 1944, at 9:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 1, 1944, to OCT. 16, 1944, and that I last saw her alive on OCT. 16 1944.

	Duration
Immediate cause of death CARDIO-RESPIRATORY FAILURE	72 HRS.
Due to GENERALIZED CARCINOMATOSIS	4 MO.
Due to CERVICAL CARCINOMA	7 YRS.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: NOT DONE.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Glenn D. Grove, M. D.
Address Union Memorial Hosp. Date signed 10/16/44

G21696 BALTIMORE CITY HEALTH DEPARTMENT ✓ G21696

CERTIFICATE OF DEATH 93 D

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 LIBERTY HGTS. AVE.
(c) Hospital or institution: CHELSEA HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3550 PARK HGTS. AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN LINK

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife ALICE A. LINK
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 6, 1861

8. AGE: Years	Months	Days	If less than one day
83	1	10	hr. min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Balto. Bargain House

FATHER
12. Name PHILIP LINK
13. Birthplace GERMANY

MOTHER
14. Maiden Name HELENA OSTRATH
15. Birthplace GERMANY

16 (a) Informant Mrs. Alice Link
(b) Address 3503 Park Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/44 (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEM.
Location WOODLAWN, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) (Date received by registrar) (b) Registrar

VS 180 OCT 18 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 16, 1944, at 9:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1/23 1943, to Oct 16 1944, and that I last saw him alive on Oct 16 1944

Immediate cause of death: Generalized Arteriosclerosis — Duration: 1 Mos.
Due to: Arteriosclerotic Heart disease
Due to:
Other Conditions None

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Louis Blum M. D.
Address 3431 Pk Heights Ave Date signed 10/17/44 M. D.

G21697

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 N1

G21697 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4021 Barrington Rd
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Sadie Cummins

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
59 60			hr. min.

9. Birthplace Russia
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Hyman Barr
13. Birthplace Russia

MOTHER
14. Maiden Name Ethel
15. Birthplace Russia

16 (a) Informant Joseph Reisade
(b) Address

17 (a) Burial (b) Date thereof 10-18-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Philadelphia Hamilton Ave
18 (a) Funeral director Jack Lewis Inc
(b) Address 1437 E. Baltimore St
19 (a) OCT 18 1944 Hunting for Middle Rd
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22 1944 to 10/17 1944 and that I last saw her alive on 10/17 1944

Immediate cause of death respiratory failure

Due to cerebral embolism

Due to generalized C.A. from breast

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Carcinoma
Major findings of operations
of autopsy: None

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence..... at..... M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....
23. Signature Isaac Rosedale M. D.
Address Sinai Hospital Date signed 10/17/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21698 / 170 C

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Erase or correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or Institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits write RURAL and give town)
(d) Street No. 2632 Francis Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Perry Pierpont Zinn

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Alcesta M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1885

8. AGE: Years	Months	Days	If less than one day
59	7	9	hr. min.

9. Birthplace Richie Co. W. Va.
(Town, county, and state)
10. Usual Occupation Machinist
11. Industry or business Riverside Copper Co.

FATHER
12. Name Thomas E. Zinn
13. Birthplace W. Va.

MOTHER
14. Maiden Name Kate Pierpoint
15. Birthplace W. Va.

16 (a) Informant Mrs. Alcesta M. Zinn
(b) Address 2632 Francis Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/44 (month) (day) (year)
(c) Cemetery or crematory Union Town
Location Pa.

18 (a) Funeral director Wm. J. Luckenbaugh Sons
(b) Address North & Pa. Ave.

19 (a) OCT 18 1944 (Date received by Registrar) Hunterton Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1944, at 2:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Ruptured Liver
Lacerated Lungs.
Due to Fractured ribs

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-17-44 at 2:05 P.M. 26/6
(b) Where did injury occur? Boone & Clinton Sts.
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by truck.

23. Signature Homer J. Brodeur M.D.
(Medical Examiner)
Date signed 10-18-44

7

G21693 ✓ X G21699

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address N. Broadway
(c) Hospital or institution: Church Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. Severna Park (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Duvall, Mr. Richard.

3 (b) If veteran, name war: No.
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1893

8. AGE: Years	Months	Days	If less than one day
51	3	10	1 hr. 30 min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Construction
11. Industry or business

FATHER
12. Name Richard Duvall.
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary E. Whittington
15. Birthplace Maryland

16 (a) Informant Mary E. Lockey
(b) Address 403 Evesham Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill Cem.
Location Annapolis Blvd.

18 (a) Funeral director John Henry Dye Earl Heer
(b) Address 715 Light St.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1944, at 4:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1944, to 10-17 1944, and that I last saw h alive on 10-17 1944.

Immediate cause of death	Duration
Debilitation	
Respiratory failure	
Due to Carcinoma of esophagus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles Steven Hatch, M. D.
Address Church Home Hospital Date signed 10-17-44

G21700 ✓ G21700

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3826 Sequoia Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3826 Sequoia Ave-15
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Dragen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 16, 1944

8. AGE: Years | Months | Days: 1 day | If less than one day: hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Leonard Dragen
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sylvia Nickelson
15. Birthplace New Jersey

16 (a) Informant Mother Sylvia Dragen
(b) Address 3826 Sequoia ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 18. 44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Hebrew
Location Belair Rd

18 (a) Funeral director Jack Lewis Inc
(b) Address 1434 E Balto St

19 (a) OCT 18 1944 (Date rec'd by registrar) (b) Huntington Wilkins, M.D. (Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1944, at 9:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1944 to 10/17 1944, and that I last saw h[illegible] alive on 10/16 1944.

Immediate cause of death	Duration
intracranial hemorrhage —	
Due to prematurity.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy Intracranial Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Raymond B. Webber M.D.
Address Sinai Hosp Date signed 10/17/44

G21701

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 119a

Registered No. G21701

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 618 Eager St (If no street give location)
(e) Citizen of foreign country? Baker (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Clifton Hamilton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-25-44

8. AGE: Years	Months	Days	If less than one day
	2	21	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Elijah Hunzin
13. Birthplace N.C

MOTHER
14. Maiden Name Isabelle Hamilton
15. Birthplace Baltimore

16 (a) Informant Records of Provident Hosp.
(b) Address Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Balto., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) (Entered by registrar) (b) Registrar, M.H.

OCT 18 1944

Turnington for Williams, M.H.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 — 16 1944, at 8 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1944, to 10-16 1944, and that I last saw him alive on 10-16 1944

Immediate cause of death: Respiratory failure — Duration: Since Sept 16

Due to: anoxemia

Due to: malnutrition, dehydration, anemia, diarrhea

Other Conditions: diarrhea, ulcerative colitis

(Include pregnancy within 3 months of death)

Date of operation: Ileostomy-Mayo-Rochester 10-13-44

Major findings of operation:

of autopsy: not reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John R. Bumingham M. D.
Address J.H.H. Date signed 10-18

G21702

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 53

Registered No. G21702

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 mos
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Middle River
(If outside city or town limits, write RURAL and give town)
(d) Street No. #1 Mainfold Court
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph (Jalasky) Tolodziecky
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Mrs Anna Jalasky
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/31/1912

8. AGE: Years	Months	Days	If less than one day
32	1	17	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)
10. Usual Occupation Unmit leader
11. Industry or business

FATHER
12. Name Paul Jalasky
13. Birthplace Poland

MOTHER
14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs. Anna Jalasky
(b) Address #1 Manifold Court, Balto.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. J. Brough
(b) Address 5345 Harford Rd.
(c) 1 18 1944 (Date rec'd by registrar) Hunting for Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1944, at 6:11 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Oct 17 1944, and that I last saw him alive on Oct 17 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Squamous cell carcinoma of pulmonary & Cachexia.	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-16-44
Major findings of operation: Squamous cell Carcinoma of perineum
of autopsy: Sq. cell Ca.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Harry J. Colfer
Address Mercy Hospital Date signed 10-17-44 M. D.

G21703

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G21703 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Cold Spring Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Parkville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 Taylor Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louise Mary Schott

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-28-1871

8. AGE: Years	Months	Days	If less than one day
72	9	18	hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Joseph Schott
13. Birthplace Germany

MOTHER
14. Maiden Name Mahnood
15. Birthplace

16 (a) Informant Mary R. Seidl
(b) Address 2819 Christopher Ave

17 (a) Burial (b) Date thereof 10-19-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director L. J. Rusch
(b) Address 530 Hayford Rd.

19 OCT 18 1944 Harrington Williams, M.D.
(Date rec'd by State Registrar) (Signature of Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1944, at 3 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1944, to Oct 16 1944, and that I last saw her alive on Oct 13 1944.

Immediate cause of death Pulmonary Tuberculosis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. M. Patterson M. D.

Address 2224 Pennsylvania Ave Date signed 10/16/44

G21704

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

485

G21704 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

Dr. White

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3313 Rosekemp Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3313 Rosekemp Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle E. Anderson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Gustav Anderson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 9-1887

8. AGE: Years	Months	Days	If less than one day
57	9	9	hr. min.

9. Birthplace Sweden (Town, county and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William Montgomery
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Carmine
15. Birthplace Md.

16 (a) Informant Mr. Gustav Anderson
(b) Address 3313 Rosekemp Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore

18 (a) Funeral director Leonard J. Rusk
(b) Address 5309 Harford Road

19 (a) (Date rec'd by registrar) (b) Registrar

Hunting for Hotbeds, Inc.

OCT 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18th 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from July 17 1944 to Oct 18 1944, and that I last saw h[illegible] alive on Oct 17- 1944

Immediate cause of death: Carcinoma (Uterine) — Duration: 4 mos.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Md.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. B. Mellott
Address 1279 Milliman St Date signed 10/18/44
M. D.

G2470547

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G21705

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1204 N. Central Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	married

6 (b) Name of husband or wife Ollie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-4-79

8. AGE: Years	Months	Days	If less than one day
65	-	11	hr. min.

9. Birthplace Md.
(Town, county, or state)

10. Usual Occupation Bootblack

11. Industry or business

FATHER
12. Name Wm Wise
13. Birthplace ? ?

MOTHER
14. Maiden Name Mary Skinner
15. Birthplace ? ?

16 (a) Informant Friends.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/18/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Grant Lane

19 (a) (b) Huntington Williamsport, Md.

OCT 18 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 15 1944, at 10:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct- 13 1944 to Oct- 15 1944, and that I last saw him alive on Oct- 15 1944.

Immediate cause of death	Duration
carcinomatosis	
Due to Carcinoma of esophagus	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Carcinoma of esophagus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Katten M. D.
Address Johns Hopkins Hosp. Date signed 10/18/44

G21706

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21706

Registered No.

JO #15977

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4lyr. 2mos. 28 da.
(e) Length of stay in Baltimore (yrs., mos., or days) Since birth

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Ba. C. H. Infirmary
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME
Annie McAllister

3 (b) If veteran, name war
nil

3 (c) Social Security Account No. NONE

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 4, 1874

8. AGE: Years 70 | Months -4- | Days 12 | If less than one day hr. min.

9. Birthplace Eastern Shore, Maryland
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Washington Parks
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Lynch
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/18/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Co. Md.

18 (a) Funeral director Gilbert Cole Inc
(b) Address 1214 E. Lanvale

19 (a) OCT 18 1944 (Date rec'd by Registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16, 1944, at 2:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-19- 1940, to 10-16- 1944, and that I last saw h. alive on 10-16- 1944

Immediate cause of death
Cerebrovascular accident — Duration: Less than 1 hr.

Due to cerebral arteriosclerosis — Duration: ?

Due to — Duration:

Other Conditions Hypertensive cardio-vascular disease — Duration: ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy No Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Emmett Smith M. D.
Address Balt. City Hosp. Date signed 10/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G21708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21707
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 24 S. Regester St. Dor
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 24 S. Regester St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Haywood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C.	Single

6 (b) Name of husband or wife –

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)

10. Usual Occupation Boat Hand

11. Industry or business –

FATHER
12. Name ? Haywood
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Buchanan
15. Birthplace Md.

16 (a) Informant Marcline Price (niece)
(b) Address 707 N. Caroline St.

17 (a) Burial (b) Date thereof 10-21-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A. H. County Md.

18 (a) Funeral director Joseph B. Locke Jr.
(b) Address 1047 N. Central Ave

19 (a) OCT 18 1947 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1947 at 7:35 P.M.

21. I certify that I took charge of the remains described above, held an Inspection-Inquest thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
(a) Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles J. Truitt M.D.
Medical Examiner.
Date signed 10/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR REGISTERING

VS 151

G21708

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

Registered No. G21708

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 416 N. Eden St. (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Robert Hayden

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1/5/1907

8. AGE: Years 37 | Months 9 | Days 11 | If less than one day ..... hr. ..... min.

9. Birthplace BALTO, Md. (Town, county, and state)

10. Usual Occupation LABORER

11. Industry or business

FATHER
12. Name Robert Keyser Sr.
13. Birthplace Md

MOTHER
14. Maiden Name Caroline Jones
15. Birthplace Md

16 (a) Informant Robert Keyser Sr.
(b) Address 416 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/44 (month) (day) (year)
(c) Cemetery or crematory MT. ZION
Location.....

18 (a) Funeral director Joseph G. Locke, Jr.
(b) Address 1304 N. Central Ave

19 (a) OCT 23 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16 1944, at 11:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Atelectasis of Lungs

Due to Ether anesthesia

Other Conditions Compound comminuted Fracture of right lower leg
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 7, 1944 5/1 9:30 P.M.
(b) Where did injury occur? Oldcamp St. near Eden
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by auto

23. Signature Robert Lee Waters M.D. Medical Examiner.

Date signed 10-17-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21709

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

G21709 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 Hollins St
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 7yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 Hollins St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Hartman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Airy E. Dempsey

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 28, 1872

8. AGE: Years 72 | Months 6 | Days 19 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Retired Foreman

11. Industry or business B+O. R.R.

FATHER 12. Name Valentine Hartman

13. Birthplace Germany

MOTHER 14. Maiden Name Cornelius Bost

15. Birthplace U.S.A.

16 (a) Informant Mrs. Wm. A. Hartman

(b) Address 1917 Hollins St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-44 (month) (day) (year)

(c) Cemetery or crematory Pine Grove

Location Mt. Airy Md.

18 (a) Funeral director Harry H. Weitzel

(b) Address 1016 Edmondson Ave.

19 (a) OCT 18 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 1943, to Oct 16 1944, and that I last saw him alive on Oct 16 1944.

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Ch. Nephritis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Albert Seagrott M. D.

Address 1724 W Lombard St Date signed Oct 18 '44

G21710

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21710 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Genl Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1432 Marshall St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Michael J. Holly

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Married.

6 (b) Name of husband or wife Mary J.

6 (c) If alive, give age years

7. Birth date of deceased (mo.) Oct. 15 1879

8. AGE: Years 65 Months 2 Days 1 If less than one day hr. min.

9. Birthplace Ireland.
(Town, county, and state)

10. Usual Occupation Coiler

11. Industry or business

FATHER
12. Name James Holly
13. Birthplace Ireland.

MOTHER
14. Maiden Name Mulrooney
15. Birthplace Ireland.

16 (a) Informant Mrs. Mary Holly
(b) Address 713 A. Woodlynn Ave. W. Fleming and Sons

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct 13 1944 (month) (day) (year)

(c) Cemetery or crematory Camden Abs J.
Location

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Leadenhall St.

19 (a) (b)
(Registrar's signature) Oct 15 1944 Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 16 1944 at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Pulmonary Edema

Due to Chronic myocardial degeneration

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct. 16 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21711 BALTIMORE CITY HEALTH DEPARTMENT G21711

CERTIFICATE OF DEATH 1929

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2018 N. Washington St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2018 N. Washington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY ANNA HUEGELMEIER

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 23, 1860

8. AGE: Years	Months	Days	If less than one day
83	11	23	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Wm. H. Huegelmeier
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Wiseman
15. Birthplace Germany

16 (a) Informant Mrs. Frances A. Bell
(b) Address 2018 N. Washington Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-18-44 (month) (day) (year)
(c) Cemetery or crematory Most Holy Redeemer
Location Balto. Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

OCT 18 1944 (Date rec'd by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION P.M.

20. DATE OF DEATH Oct. 16 1944 at 8.15 M

21. I certify that death occurred on the date above stated; that I attended deceased from SEP 16 1944, to OCT 16 1944, and that I last saw HER alive on OCT 16 1944.

Immediate cause of death Coronary thrombosis
Due to Cerebral Embolism
Due to Chr Endocarditis
Due to Arterio-sclerosis
Other Conditions Hypertention
(Include pregnancy within 3 months of death)

Duration
Coronary thrombosis 12 days
Cerebral Embolism
Chr Endocarditis
Arterio-sclerosis
Hypertention

Date of operation None
Major findings of operation: None
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide None
(b) Date of occurrence None at M
(c) Where did injury occur? None
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? None While at work? No
(Specify type of place)
(e) Means of injury None
23. Signature Otto H. Duker M.D.
Address 928 E. North Ave Date signed OCT 17 1944

G21712

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

G21712 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2111 St. Paul St.
(c) Hospital or institution: 11
(d) Length of stay in hospital or inst. (yrs., mos., or days) ----
(e) Length of stay in Baltimore (yrs., mos., or days) Over 50 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 805 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? --------- (Yes or No)
If yes, name country ---------

3 (a) FULL NAME Mary J. Martin

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 10, 1869

8. AGE: Years 75 | Months 5 | Days 7 | If less than one day -- hr. -- min.

9. Birthplace Troy, New York (Town, county, and state)

10. Usual Occupation None

11. Industry or business -------

FATHER
12. Name Michael Martin
13. Birthplace Ireland

MOTHER
14. Maiden Name Ellen Feely
15. Birthplace Ireland

16 (a) Informant Miss Teresa Martin
(b) Address 2111 St. Paul Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Meaks and Son
(b) Address OCT 18 1944 N. Calvert Street

19 (a) ---------- (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1944 to Oct 17 1944, and that I last saw h-r alive on Oct 16 1944

	Duration
Immediate cause of death: Hypostatic pneumonia	2 days
Due to: Carcinoma of Oesophagus	1 yr. ?
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. H. Hayward M. D.
Address 115 E Saratoga Date signed Oct 19 1944

E. H. Hayward

G21713

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21713 Registered No. 808

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Baltimore, Md.
(c) Hospital or institution South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1024 S. Charles Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraldine M. Green

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29, 1941

8. AGE: Years 3 | Months 0 | Days 18 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Edward J. Green
13. Birthplace Philadelphia Pa.

MOTHER
14. Maiden Name Genevieve Christopher
15. Birthplace Baltimore Md.

16 (a) Informant Edward J. Green
(b) Address 1024 S. Charles Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20/1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. A. Co., Md.

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light Street

19 (a) Received (b) Huntington Williams Registrar
OCT 18 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1944, at 7:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Encephalitis.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally, M.D.
Medical Examiner.
Date signed October 17, 1944.
Per. Howard J. Thomsen, M.D.

G21714

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21714 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2½h.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 434 E. Monument St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME James Phyppe

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret Phyppe

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1877

8. AGE: Years 67 | Months - | Days 6 | If less than one day hr. min.

9. Birthplace Calvert Md. (Town, county and state)

10. Usual Occupation Milk Route Checker

11. Industry or business Dairy

FATHER 12. Name Louis Phyppe
13. Birthplace

MOTHER 14. Maiden Name Frances Meade
15. Birthplace

16 (a) Informant Mrs. Margaret Phyppe
(b) Address 434 E. Monument St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location

18 (a) Funeral director Geo. M. Gaul & Son
(b) Address 811 N. Howard St.

OCT 18 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 19 44 at 3 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 19 44 to 10/17 19 44 and that I last saw h. alive on 10/17 19 44

Immediate cause of death Cerebro spinal accident — Duration

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Earl Myers M.D.
Address Franklin Sq. Hosp. Date signed 10/18/44

G21715 KEMPF G21715

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 Caroline St.
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 73 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 Aisquith St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Amelia Kempf (Amelia A. Kempf.)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife George Kempf.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/12/71

8. AGE: Years 73 | Months | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore 2, Md (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Aloysius Schmitt
13. Birthplace Germany

MOTHER
14. Maiden Name Eva Peck
15. Birthplace Germany

16 (a) Informant George Geo. Kempf Jr.
(b) Address 1643 Aisquith St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10/20/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd

18 (a) Funeral director George J. Smith Inc.
(b) Address 1735 Hartford Ave
Date received by registrar OCT 18 1944 (b) Huntington Williams, Registrar

VS 150 (over)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1944 at M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/16/44 to 10/17 1944 and that I last saw h[illegible] alive on 10/16 1944

Immediate cause of death Postoperative pneumonia due to prolonged hospitalization. | Duration

Due to Fracture of the neck of the left femur. |

Due to |

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/9
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 7-7-44 at ? M
(c) Where did injury occur? 1643 Aisquith St. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no (Specify type of place)
(e) Means of injury Fell out of chair at home

23. Signature [illegible] M. D.
Address 1400 N. Caroline St Date signed 10/17/44

Approved by Howard J. Mercer, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21716

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G21716 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6000 Bellona Ave.
(c) Hospital or institution:
Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Annapolis
(If outside city or town limits, write RURAL and give town)
(d) Street No. Market St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Holley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Paul Holley

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): September 7, 1857

8. AGE: Years 87 | Months 1 | Days 11 | If less than one day hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: John Bohlman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Elizabeth Riddle
15. Birthplace: Germany

16 (a) Informant: Mr. Andreas Z. Holley
(b) Address: Market St., Annapolis, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory: National Cemetery
Location: Annapolis, Md.

18 (a) Funeral director: E.W. Pomeroy
(b) Address: 1005 W. Baltimore St.

19 (a) OCT 18 1944 (b) (Date received by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 44 at 4.45AM

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 19 44, to Oct 18 19 44, and that I last saw her alive on Oct. 17 1944.

Immediate cause of death: Chronic Myocarditis

Duration: 1 day

Due to:

Due to:

Other Conditions: Arteriosclerosis & Chronic Nephritis

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: [illegible]
Address 117 W. 25th Date signed Oct 19 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21717

TB 76303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21717

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 502 W. Preston St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Owens

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	C	Married

6 (b) Name of husband or wife William A. Owens
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15th 1861

8. AGE: Years 83 | Months 4 | Days 19 | If less than one day 29 hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Jacob Richardson
13. Birthplace Maryland

MOTHER
14. Maiden Name Leah Palmer
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Arbutus Cem.
Location
18 (a) Funeral director Chas H. Algaier
(b) Address 13 or McCulloh St

19 (a) OCT 18 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14, 1944 19 4.15 P.M. at M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/24 1942 to 10-14 1944, and that I last saw h[illegible] alive on 10-14 1944

Immediate cause of death Bronchopneumonia — Duration 2 wks.

Due to

Due to

Other Conditions Arteriosclerotic heart disease — ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm Kenneth Smith M. D.
Address Balt. City Hosp Date signed 10/18/44

Huntington Williams, M.D.

G21718 ✓ G21718

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4031 Norfolk Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4031 Norfolk Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Goldie Brooks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Morris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5 1879

8. AGE: Years 65 | Months 9 | Days 13 | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Charles Nelson
13. Birthplace Russia

MOTHER
14. Maiden Name Marcy Monen
15. Birthplace Russia

16 (a) Informant Mrs Rose Monen
(b) Address 4031 Norfolk Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 19, 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) (Date received by registrar) OCT 19 1944 (b) Hunting to Williamsport Md

VS 150

MEDICAL CERTIFICATION 8.30

20. DATE OF DEATH October 18, 1944 at A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 2/6 1943 to 10/18 1944, and that I last saw h[illegible] alive on 10/18 1944.

Immediate cause of death: Coronary Thrombosis — Duration: Suddn

Due to: Arterio-Sclerotic Cardio-

Due to: Vascular Renal Disease — Duration: 7

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph L. Blum M.D.
Address 1206 E. Fenton St Date signed 10/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21719

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

G21719 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1617 Lefton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1617 Lefton St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Joseph Zekas (Jacobs)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed
6 (b) Name of husband or wife Veronica
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years 79 | Months | Days | If less than one day hr. min.

9. Birthplace Lith (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith

MOTHER
14. Maiden Name ?
15. Birthplace Lith

16 (a) Informant Frank Zekas
(b) Address 1617 Sefton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location Belair Rd

18 (a) Funeral director Joseph Kaminskas Inc
(b) Address 602 Washington Blvd

19 (a) OCT 19 1944 (Date filed by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17, 1944 at 8:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 10, 1944 to Oct 17, 1944 and that I last saw h[illegible] alive on Oct 17, 1944

Immediate cause of death: Acute Heart Failure — Duration: 2 days
Due to: Arteriosclerosis
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 6 Washington Blvd Date signed 10/18/44

Huntington Hospital

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G21720

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution:
Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Day
(e) Length of stay in Baltimore (yrs., mos., or days) 63 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 200 S. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary E. O'Ferrall

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Mr. Alfred O'Ferrall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/18/81

8. AGE: Years	Months	Days	If less than one day
63	-10	29	-- hr. --- min.

9. Birthplace Balt.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James E. Farrell
13. Birthplace Maryland

MOTHER
14. Maiden Name Charlotte Meyers
15. Birthplace Maryland

16 (a) Informant Alfred J. O'Ferrall
(b) Address 200 S. Augusta Avenue

17 (a) Burial (b) Date thereof 10/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 1 OCT 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17/44 19 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 19 44 to 10/17 19 44, and that I last saw her alive on 10/17 19 44

Immediate cause of death	Duration
Congestive Heart Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Francis L. Grumbine M. D.
Address Bon Secours Hosp. Date signed 10/17/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1575 G21721 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Linden & Madison Sts
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6011 Highgate Drive (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

F 70552

3 (a) FULL NAME Geraldine C. Griffith — Geraldine Cornelia Griffith

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: Single
6 (c) If alive, give age 1942 years
7. Birth date of deceased (mo., day, yr.) Dec. 16, 1943

8. AGE: Years	Months	Days	If less than one day
1	10	1	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name James H. Griffith
13. Birthplace New York

MOTHER
14. Maiden Name Elinor Spicknall
15. Birthplace Baltimore, Md.

16 (a) Informant Mrs. Elinor S. Griffith
(b) Address 6011 Highgate Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

OCT 19 1944 (b) Hunter for Williams Funeral Home

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1944, at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1944 to 10/17 1944, and that I last saw her alive on 10/17 1944.

Immediate cause of death [redacted] Subarachnoid Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Subarachnoid Hemorrhage

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M.D.
Maryland General Hospital Date signed 10/19/44

For Dr C. J. Jednacki, by Howard J. Masecar, M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

328297 G21722

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55 V

G21722 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Hamilton Court apartments 307 Ridgewood Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Eleanor Allison — Eleanor Ward Allison

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-23-23

8. AGE: Years 21 | Months 0 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Secretary
11. Industry or business

FATHER 12. Name J. Ward Allison
13. Birthplace Niles Ohio

MOTHER 14. Maiden Name Beatrix Steinacker
15. Birthplace Baltimore Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 OCT 19 1944 (Date received by Registrar) (b) Huntington Mills Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17- 1944 at 5.25 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 8-1- 1944 to 10-17- 1944 and that I last saw her alive on 10-17- 1944

Immediate cause of death: Cachexia, anemia, cardiac failure — Duration: 2 mo 2 days
Due to: Lymphosarcoma, Generalized — ? 6 mo.
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. Wayne D. Richardson M.D.
Address Johns Hopkins Hospital Date signed 10/19/44

G21723

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55c

Registered No. G21723

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 611 E Fort ave
(c) Hospital or institution: South Balto. General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 611 E Fort Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Clytie Dowe Etzler

3 (b) If veteran, name war: None

3 (c) Social Security Account No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Frank L.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2 - 8 - 1886

8. AGE: Years 58 | Months 8 | Days 9 | If less than one day hr. min.

9. Birthplace UNION BRIDGE, Md.
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name Ernest Kelly
13. Birthplace Md

MOTHER
14. Maiden Name Laura Delphey
15. Birthplace Md.

16 (a) Informant husband
(b) Address 611 E. Fort Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Edmondson Ave

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves

19 (a) (Date rec'd by registrar) (b) Huntington Williams

VS 1 OCT 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1944 at 10 35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1944 to Oct. 17, 1944 and that I last saw her alive on Oct. 17, 1944.

Immediate cause of death: Coronary thrombosis — Duration:

Due to Hypertensive C-V. disease

Due to Chronic nephritis

Other Conditions Ca. of thyroid?
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation

of autopsy: Above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Ehrlich M.D.
M.R. Address 1213 Light St Date signed 10-17-44

G21724 BALTIMORE CITY HEALTH DEPARTMENT ✓ G21724
CERTIFICATE OF DEATH 61 Registered No.

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Raymond Ave
(c) Hospital or institution: WEST BALT. GEN HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md/ (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3219 Belmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN T. Schriefer SCHRIEFER

3 (b) If veteran, name war | 3 (c) Social Security Account No. ?

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Anna M. Schriefer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 23, 1870

8. AGE: Years 74 | Months 0 | Days 25 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation Electrician Retired

11. Industry or business B & O R.R. Co.

FATHER 12. Name Not Known
13. Birthplace " "

MOTHER 14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mrss Josephine Bentley
(b) Address 3219 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Md.

18 (a) Funeral director Wm. J. Tickner & Sons, Inc.
(b) Address North & Pa. Aves.

19 (a) OCT 19 1944 (Date rec'd by registrar) Huntington Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 18 1944 8:55 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10 1944 to 10/18 1944, and that I last saw h[illegible] alive on 10/18 1944.

Immediate cause of death Leukosarcoma probably acute nephritis Influenza — Duration

Due to

Due to

Other Conditions DIABETES MELLITUS RT. ABDOM. WALL ABSCESS
(Include pregnancy within 3 months of death)

Date of operation 10-15-44

Major findings of operation: ABSCESS IN ABDOM. WALL in RIGHT SIDE

of autopsy: Pending — Date

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Roscoe Baldwin
Address Med. Baltimore General Hosp. Date signed 10/18/44

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21725 94a

Registered No. G21725

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 514 Winston Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 514 Winston Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE F. DAWSON

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Garland H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 16, 1893

8. AGE: Years	Months	Days	If less than one day
51	3	1	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOHN B. BLEY
13. Birthplace HERMANY

MOTHER
14. Maiden Name ANNIE L. EREK
15. Birthplace BALTIMORE

16 (a) Informant MR. GARLAND H. DAWSON
(b) Address 514 WINSTON AVE

17 (a) BURIAL (b) Date thereof 10/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory LORRAINE CEM.
Location WOODLAWN, MD.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address BALTO., MD.

19 (a) OCT 19 1944 (Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1944, at 2:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 19 , to 10/17 19 , and that I last saw h alive on 10/17 19 44.

Immediate cause of death	Duration
acute Cardiac dilatation	
Due to Coronary thrombosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature S. C Feldman
Address 1440 E Balto M Date signed M. 10 D. 18/44

G21726

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G21726

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore - Maryland
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 634 N. Mulberry Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence Porter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/4/1905

8. AGE: Years 39 | Months 2 | Days 13 | If less than one day hr. min.

9. Birthplace Arnold, Md.
(town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER 12. Name Walter Porter

13. Birthplace A. A. Co.

MOTHER 14. Maiden Name Blanch Griffin

15. Birthplace A. A. Co.

16 (a) Informant Virginia Cook

(b) Address R2, Box 592 Annapolis

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location Arnold, Md.

18 (a) Funeral director J. B. Johnson

(b) Address Annapolis, Md.

OCT 19 1944 (Date rec'd by Registrar) (c) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1944, at 12:10 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury Oct. 17, 1944 at 10:55 A.M. 24/1

(b) Where did injury occur? Pier #7, Locust Point

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury While unloading from steamship fell between ship & pier & fell into water. Howard Weddell M.D.

23. Signature Medical Examiner.

Date signed October 17, 1944.

VS 151

G21727

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

166

G21727
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) 54 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1738 Llewellyn Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willie Brown

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5/16/1900

8. AGE: Years 44 | Months 4 | Days 28 | If less than one day ____ hr. ____ min.

9. Birthplace Farmville Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Willie Brown Sr
13. Birthplace Va

MOTHER
14. Maiden Name Mattie Logan
15. Birthplace Va

16 (a) Informant Ethel Richards
(b) Address 1028 N Gay St

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 10 19 44 (month) (day) (year)
(c) Cemetery or crematory Farmville Va
Location Virginia

18 (a) Funeral director Raynor Sanders
(b) Address 1112 E Preston St

19 OCT 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14- 19 44, at 10 45 PM

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Gun shot wounds of heart, lung and liver

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-14- at 10.25 P M.
(b) Where did injury occur? 701 Llewellyn Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public - Tavern While at work? No
(d) Means of injury Fire-arm - revolver

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 10-15-44

5 G21728

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

180

Registered No. G21728

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Johns Hopkins Hospital D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1803 E. Chase Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Rosemond

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Perry

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 30, 1874

8. AGE: Years 70 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name

13. Birthplace unknown

MOTHER 14. Maiden Name Mary Chanty

15. Birthplace S. C.

16 (a) Informant Walter Cannon

(b) Address 1803 E Chase St

17 (a) Removal (b) Date thereof Oct 19/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location Greenmount Ave & Oak

18 (a) Funeral director Mrs. Robert A. Elliott Dept.

(b) Address 129 N. Caroline St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

OCT 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1944, at 11:45 A. M.

21. I certify that I took charge of the remains described above, held an Inspection + Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
Asphyxiation

Due to 2nd + 3rd. degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-17- at 11.26 A M. 7/4

(b) Where did injury occur? 1803 E. Chase St.

(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No

(d) Means of injury Conflagration

23. Signature Howard A. Clements M.D.
Medical Examiner.

Date signed October 17, 1944.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21729

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83c

G21729 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 N. 37th Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Josephine Tipton

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 28. 1874
8. AGE: Years 70 Months 7 Days 19 If less than one day hr. min.
9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation Seamstress
11. Industry or business

FATHER
12. Name John H. Tipton
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Rebecca Jones
15. Birthplace Maryland

16 (a) Informant George E. Tipton 1st
(b) Address 1109 N. 37th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20. 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3921 Falls Road

OCT 19 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17. 1944 at 9:30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 15 1944 to Oct 16 1944 and that I last saw h[er] alive on Oct 16 1944.

Immediate cause of death Uremia — Duration

Due to Cerebral softening.

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. N. McFaul Jr. M. D.
Address 1800 N. Charles St Date signed Oct 18/44

G21730

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G21730

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1610 E. Preston St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1610 E. Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William A. Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Rose Miller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 9, 1859

8. AGE: Years 85 | Months - | Days 8 | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Unemployed

11. Industry or business

FATHER 12. Name Unknown
FATHER 13. Birthplace "

MOTHER 14. Maiden Name Unknown
MOTHER 15. Birthplace "

16 (a) Informant Rose Miller
(b) Address 1610 E Preston St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brantley Ave

OCT 19 1944 (Date rec'd by registrar) Waiting for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17- 1944 at 4A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 30 1944 to Oct 16 1944 and that I last saw h[illegible] alive on Oct 16 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 16 days

Due to: Old age & Arteriosclerosis

Due to: —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. H. Walters M. D.
Address 1443 E. Eager Street Date signed 10/18/44

G21731

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21731

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 748 Pierpont
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 748 Pierpont (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Street — EMMA STREET

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	M

6 (b) Name of husband or wife Frederick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 29-1906

8. AGE: Years	Months	Days	If less than one day
38	-	17	hr. min.

9. Birthplace Person Co - Va. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Frederick Street
(b) Address 748 W. Pierpont St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-19-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Wilson

18 (a) Funeral director Mrs. Katie Pall Adams
(b) Address 3[illegible] N. Schroeder St

19 (a) OCT 19 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1944 at 7 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Oct 16 1944 and that I last saw h[illegible] alive on Oct 16 1944.

Immediate cause of death Carcinoma of Cervix — Duration 6 mos

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.
Address 74 W Pierpont Date signed 10/17/44

VS 180

G21732

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45F

Registered No. G21732

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in years, months, days, hours, minutes; the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 N. Hilton Road
(c) Hospital or institution: Ashburton House ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, 31.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2011 Bank Street
2022
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marty Joseph Juras

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of [redacted] or wife Veronica

6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
51			hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Master Electrician

11. Industry or business

FATHER
12. Name Casimir Juras
13. Birthplace Austria

MOTHER
14. Maiden Name Tekla Turcyn
15. Birthplace Poland

16 (a) Informant Mrs. Theresa Wojtowicz
(b) Address 317 Overhill Road

17 (a) Burial (b) Date thereof 10-21-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George R Weber
(b) Address 705-S Linn Street

19 (a) Filed OCT 19 1944 (b) Huntington for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17th 1944, at 12 noon P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Oct 17 1944, and that I last saw him alive on Oct 17 1944.

Immediate cause of death	Duration
Carcinoma Tonsil Left	1 yr -
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Grant E Ward, M.D.
Address 214 Medical Arts Bldg Baltimore, Md Date signed 10/19 1944

G21733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G21733

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct, age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2501 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

13

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl Stewart Carey

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 21, 1901

8. AGE: Years	Months	Days	If less than one day
44	7	19	hr. 24 min.

9. Birthplace Baltimore Co. Md.
(town, county, and state)
10. Usual Occupation Steel worker
11. Industry or business
FATHER 12. Name Harry Carey
13. Birthplace Baltimore Co. Md.
MOTHER 14. Maiden Name Estelle Lewis
15. Birthplace Baltimore Co. Md.
16 (a) Informant Miss Burgh Carey
(b) Address 2501 Madison Ave.
17 (a) Burial (b) Date thereof Oct. 18, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Pine Grove Cem.
Location White Hall, Md.
18 (a) Funeral director Mrs. Geo. A. Holland
(b) Address 642 Druid Hill Ave.
19 (a) OCT 19 1944 (b) Registrar Huntington Williams, M.D.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/15 1944, at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/11 1944, to 10/15 1944, and that I last saw him alive on 10/15 1944.

Immediate cause of death	Duration
Due to Lobar Pneumonia	5 days
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Carsey C. Johnson M. D.
Address 1812 Penna Ave Date signed 10/18/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21734

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 837

G21734
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1542 William St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1542 William St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Anna Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife George W. Taylor
6 (c) If dive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6. 1866

8. AGE: Years	Months	Days	If less than one day
78	9	11	hr. min.

9. Birthplace Va
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Elisha Claywell
13. Birthplace Va.

MOTHER
14. Maiden Name Sarah Hart
15. Birthplace Va.

16 (a) Informant Mrs. Walter Hurley
(b) Address 1542 William St

17 (a) Burial (b) Date thereof 10-21-45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore Md.

18 (a) Funeral director Jos Howard Strong
(b) Address 3707 W. North Ave.

19 (a) (Date rec'd by Registrar) Oct 19 1945 Huntington Williams W.Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17 1945, at 4:20 p. M

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 25/44 to Oct 17/45
and that I last saw h.e alive on Oct 17/45

Immediate cause of death
Cerebral Hemorrhage
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration
Oct 17

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thos B Holland M.D.
Address 1203 Eutaw Date signed Oct 17 45

78 150

62755 X ✓ 621733

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) A. D. a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. Co.
(c) City or town Crownsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Ohler ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1944

8. AGE: Years	Months	Days	If less than one day
	4	9	hr. min.

9. Birthplace Herald Harbor Crownsville, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George W. Ohler
13. Birthplace Md. Woodstown Pa

MOTHER
14. Maiden Name Dorothy C. Christner
15. Birthplace Berlin, Pa.

16 (a) Informant Mr. George W. Ohler
(b) Address Herald Harbor, Crownsville, Md.

17 (a) Burial (b) Date thereof Oct. 19 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie

18 (a) Funeral director Thomas W. Singleton (C.U.)
(b) Address Glen Burnie Maryland

19 (a) OCT 19 1944 (b)
Date rec'd by reg. Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1944, at 3 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pneumonia Lobular

Due to Chronic Dermatitis.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. & W. Gallenkamp M.D.
Medical Examiner.
Date signed October 19, 1944.

Huntington Williams M.D.

G21736

Subject to approval of Medical Examiner:

BALTIMORE CITY HEALTH DEPARTMENT

JO #20989

CERTIFICATE OF DEATH 1944

Registered No. G21736

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1220 Aisquith St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Gallagher

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 23, 1883

8. AGE: Years	Months	Days	If less than one day
60	11	16	hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Patrick Gallagher
13. Birthplace Ireland

MOTHER
14. Maiden Name Sarah Gallagher
15. Birthplace Ireland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 18 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1944 (Date rec'd by registrar) (b) Hilton Williams M.D. Registrar

VS 150

Subject to approval of Medical Examiner:

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9, 1944, at 12:10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-7 1944, to 10-9 1944 and that I last saw h.i.m. alive on 10-9 1944.

Immediate cause of death: Respiratory Insufficiency — Duration 5 min.
Due to: Pentothal Anaesthesia ? 5 min.
Other Conditions: Malnutrition, Carcinoma Tongue — 3 mos.
(Include pregnancy within 3 months of death)
Date of operation: not performed
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide anaesthetic
(b) Date of occurrence 10-9-44 at 12 M.
(c) Where did injury occur? operating room (City or town) Balto. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? City Hospital While at work? No
(Specify type of place)
(e) Means of injury

23. Signature R. M. Cunningham M. D.
Address Balto City Hospitals Date signed 10-9-44

3249 Subject to approval of Medical Examiner: N.L. Wollenweber M.D. Asst to Q

PLEASE WRITE PLAINLY, WITH UNFADING INK. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21737

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9/a

G21737

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 W. Saratoga St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Rice

3 (b) If veteran, name war: No | 3 (c) Social Security Account No.:

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 7. 1885

8. AGE: Years: 58 | Months: 10 | Days: 11 | If less than one day: hr. min.

9. Birthplace: Bath, Maryland (Town, county, and state)

10. Usual Occupation: None

11. Industry or business: None

FATHER
12. Name: Nicholas Rice
13. Birthplace: Md

MOTHER
14. Maiden name: Barbara Thomer
15. Birthplace: Md

16 (a) Informant: Mrs Florence Rice
(b) Address: 2033 W Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/28/44 (month) (day) (year)

(c) Cemetery or crematory: Mt Olivet
Location: Baltimore Md

18 (a) Funeral director: Wilson & Son
(b) Address: 1219 E Fayette St

19 OCT 19 1944 (Date rec'd by registrar) Arlington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1944, at 11:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/ 1944 to 10/18 1944, and that I last saw her alive on 10/18 1944.

Immediate cause of death	Duration
Sub-centy[illegible] endocarditis	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: Splenic anemia, heart valve lesions

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: J. Carl Myers M.D.

Address: Franklin Sq. Hosp. Date signed: 10/21/44 M/D.

4610 G21738 — BALTIMORE CITY HEALTH DEPARTMENT — G21738

CERTIFICATE OF DEATH

131a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 31 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Forest
(If outside city or town limits, write RURAL and give town)
(d) Street No. 814 Forest Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Johanka Jansen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-1-18

8. AGE: Years	Months	Days	If less than one day
25 25	10	18	hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER
12. Name Frederick Jansen
13. Birthplace Md.

MOTHER
14. Maiden Name Anna Green
15. Birthplace Md

16 (a) Informant Rhonda.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Balto.

18 (a) Funeral director Wm Cook Inc
(b) Address 1217 St Paul St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150 OCT 19 19 Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct- 18 1944, at 11.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept- 19 1944, to Oct 18 1944, and that I last saw him alive on Oct 14 1944.

	Duration
Immediate cause of death: Uremia	
Due to: Chronic glomerulonephritis	?
Due to: ? arteriosclerotic glomerulo-sclerosis	
Other Conditions: ? malignant hypertension	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Abraham Gorsen

Address Johns Hopkins Hospital Date signed 10-19 M. D.

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

G21739

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓G21739 Registered No. Over 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline St
(c) Hospital or institution:
St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Winston ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Leignan (Siegman)

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or wife~~
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-22-67

8. AGE: Years 77 | Months 7 | Days 25 | If less than one day ... hr. ... min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Conrad Siegman
13. Birthplace Unknown

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs Helen Macumber
(b) Address 313 Winston Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)

(c) Cemetery or crematory Baltimore
Location Baltimore Md

18 (a) Funeral director Wilson & Son
(b) Address 1217 E Lond St

19 (a) ... (Date rec'd by registrar) (b) Huntington Registrar

OCT 19 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17 1944, at 8:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1944 to 10-17 1944, and that I last saw him alive on 10-17 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hospital Date signed 10-17-44

G21740

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10 G21740 Registration No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1/4 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1107 Barclay
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Swan J Brunoson

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:
4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frances
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Sept 2, 1894
8. AGE: Years: 50 | Months: 6 | Days: 16 | If less than one day: hr. min.
9. Birthplace: Sweden (Town, county, and state)
10. Usual Occupation: Designer
11. Industry or business: Textile & Gear Engg Co

FATHER
12. Name: Unknown
13. Birthplace: Sweden

MOTHER
14. Maiden Name: Unknown
15. Birthplace: Sweden

16 (a) Informant: Frances Brunoson
(b) Address: 1107 Barclay St
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory: Waynesboro
Location: Waynesboro, Pa
18 (a) Funeral director: Milburn Bros Inc
(b) Address: 121 Hunter St Walverton, MD
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 18 1944, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1944, to 10-18 1944, and that I last saw him alive on 10-18 1944.

Immediate cause of death: Respiratory Failure
Due to: Uremia + Pneumonia
Due to: Kidney failure
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Yes.

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: A. M. Bacon Jr M. D.
Address: St Joseph's Hosp. Balto Date signed 10-18-44

M. D. B 1288-9

G21741 ✓ G21741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH 52a

Registered No.....

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1435 Hull St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S. If of foreign birth 44 yrs. mos. ds.

2. FULL NAME Stanislaus Joseph Lewandowski

(a) Residence: No. 1435 Hull St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Clementine Lewandowski

6. DATE OF BIRTH (month, day, year) March 19 1881

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	6	27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Steveodre

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Poland

FATHER

13. NAME Joseph Lewandowski

14. BIRTHPLACE (city or town) (State or country) Poland

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Poland

17. INFORMANT Sophia Lewandowski
(Address) 1435 Hull Street

18. BURIAL, CREMATION, OR REMOVAL
Place Holy Rosary Cem. Date Oct 20 1944

19. UNDERTAKER John F. Weber
(Address) 401 S. Chester Street

20. FILED OCT 19 1944 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 10 / 16 / 44 19

22. I HEREBY CERTIFY, That I attended deceased from October 19 43 to 10 / 16 19 44

I last saw h[illegible] alive on Oct 16 19 44 Death is said to have occurred on the date stated above, at 11:30 P.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of right Kidney	
Other contributory causes of importance:	

Name of operation..... Date of.....

What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external cause (violence) fill in also the following:

Accident, suicide, or homicide?..... Date of injury..... 19.....

Where did injury occur?.....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased?

.....If so, specify.....

(Signed) Isaac Miller M. D.

(Address) 1225 S. Chester St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. 3

G21742

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157E

Registered No. G21742

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner Ave - DeKalb St
(c) Hospital or institution: W. Balto. Gen. Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 4 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 4003 Colbourne Rd (If outside city or town limits, write RURAL and give town)
(d) Street No. Balto. Md. (If rural give location)
(e) Citizen of foreign country? Colored (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Bailey
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/44

8. AGE: Years	Months	Days	If less than one day
			4 hr. 28 min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Elwood Allen Bailey
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Anna Frances Heckwolf
15. Birthplace Balto. Md.

16 (a) Informant L. Nigh, R.N.
(b) Address W.B.G.H.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 19 1944
18 (a) Funeral director Commissioner of Health
(b) Address
19 OCT 19 1944 (Date rec'd by registrar) (b) Livingston Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1944, at 1 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Oct 19 1944, and that I last saw him alive on Oct 17 1944.

Immediate cause of death	Duration
Cardio-Respiratory Failure	
Due to Prematurity	
Congenital Heart	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Dow M.D.
Address West Balto Gen Hosp Date signed 10/19/44

VS 150

F 2242

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21743

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

Registered No. G21743

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dakeland & Ragner
(c) Hospital or institution: W. Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2735 Glendale Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Shafer - Ray Louis, Jr.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/16/44

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Ray Louis Shafer, Sr
13. Birthplace Sunbury Pa.

MOTHER
14. Maiden Name Nora Catherine Rommel
15. Birthplace Balto Md.

16 (a) Informant L. High R.N.
(b) Address W.B.G.H.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 19 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 19 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1944, at 11 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Oct 16 1944, and that I last saw him alive on Oct 8 1944

Immediate cause of death	Duration
Cardiac - Resp. Failure	
Due to Prematurity	
Due to Congenital Heart	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Day M. D.
Address West Balto Gen Hosp Date signed 10/16/44

VS 150

2243

G21744

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Register's No. G21744

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Dukeland & Rayner
(c) Hospital or institution: W. Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3515 E Monument Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Rohrnacher

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Girl	W.	

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/14/44

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Louis Rohrnacher
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Margaret Belle Jones
15. Birthplace Chance, Md.

16 (a) Informant L. High
(b) Address W.B.C.H.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 19 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 19 1944 (Date rec'd by registrar) (b) Hunter for Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1944, at 1 06 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1944 to 10-18 1944, and that I last saw h[illegible] alive on 10-18 1944.

Immediate cause of death Cardio-Resp. Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Day M. D.
Address West Balto Gen Hosp. Date signed 10/19/44

2241

G21745

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

G21745
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 336 Lafayette Ave. & John St.
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Grafton
(If outside city or town limits, write RURAL and give town)
(d) Street No. 215 W. Boyd St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Letha Evelyn Shaw.

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: M.

6 (b) Name of husband or wife: Fred. Harold Shaw.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-13

8. AGE: Years 31 | Months 0 | Days 14 | If less than one day: 7 hr. 13 min.

9. Birthplace Buchanan W. Va.
(Town, county, and state)

10. Usual Occupation H. wife

11. Industry or business

FATHER
12. Name Homer Claude
13. Birthplace W. Va.

MOTHER
14. Maiden Name Zillah Slaughter
15. Birthplace W. Va.

16 (a) Informant Patient
(b) Address Same.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/19/44 (month) (day) (year)
(c) Cemetery or crematory Blue Mont Cem.
Location Grafton, W. Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by Registrar) OCT 19 1944 (b) Harriet Williams Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19 1944 at 2:13 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1944 to 10-19 1944 and that I last saw h[illegible] alive on 10-19 1944.

Immediate cause of death	Duration
Acidosis	2 days.
Due to ? Malignant Lymphoma	3
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. S. Garnett M. D.
Address Hosp. for the Women of Md. Date signed 10-19-44

G21746

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G21746 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hr.
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Harford Rd. (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Manuel.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15.

8. AGE: Years	Months	Days	If less than one day
			5 hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation ✓
11. Industry or business

FATHER
12. Name Peter Manuel
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Dorothy Bressano
15. Birthplace Md.

16 (a) Informant Father.
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 19 1944

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 19 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 15 1944, at 930 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 to Oct 15; and that I last saw h alive on Oct 1519 44

Immediate cause of death Resp Failure

	Duration
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Jewett M. D.
Address Univ Hosp Date signed 10-15-44

V8 150

2245

G21747

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G21747 Registered No. 1190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Hanover St.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 wks
(e) Length of stay in Baltimore (yrs., mos., or days) 6 wks

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1148 N. Calhoun St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Henry "B". Baby Girl Henry
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	B	S

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Aug 23, 1944

8. AGE: Years	Months	Days	If less than one day
	1	23 20	— hr. — min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Child
11. Industry or business —

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Beatrice Henry
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 19 1944

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 19 1944 (Date rec'd by registrar) (a) Hunter for Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13 1944, at 12:01 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 13 1944, and that I last saw her alive on Oct 12 1944.

Immediate cause of death	Duration
Respiratory failure	6 wks
Due to Dehydration	
Due to Prematurity	
Other Conditions Anemia	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — — — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —
23. Signature Charles Edw. Cattell
Address University Hospital Date signed 10/13/44 (M. D.)

2244

G21748 BALTIMORE CITY HEALTH DEPARTMENT G21748

CERTIFICATE OF DEATH 13a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1007 E Lanvale St.
(c) Hospital or institution: **********
(d) Length of stay in hospital or inst. (yrs., mos., or days) *****
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1007 E Lanvale St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country **********

9-9

3 (a) FULL NAME Nellie Morris Taylor

3 (b) If veteran, name war **********
3 (c) Social Security Account No. *** None

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife James A Taylor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 7, 1868

8. AGE: Years 76 | Months 9 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER 12. Name James T Lawson
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Evelyn E Cobb
15. Birthplace Baltimore Md.

16 (a) Informant Samuel Taylor (Son)
(b) Address 1007 E Lanvale St,

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/44 (month) (day) (year)
(c) Cemetery or crematory Moreland Memorial Park
Location Parkville Baltimore Co.

18 (a) Funeral director J. Melville Jenkins.
(b) Address 2713 Kirk Ave

19 (a) OCT 19 1944 (Registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 15 1944 to Oct 17 1944, and that I last saw her alive on Oct 17 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 days
Due to Arteriosclerotic Cardiovascular Renal Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Wolfe M. D.
Address 1331 E Chase St Date signed 10-19-44

G21749 BALTIMORE CITY HEALTH DEPARTMENT G21749
CERTIFICATE OF DEATH 170C Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 1202 N. Bolling Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George W. Strut

3 (b) If veteran, name war —
3 (c) Social Security Account No. 239-22-1939

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mandie Strut nee Parker 6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) July 13-1906

8. AGE: Years 38 | Months 3 | Days 6 | If less than one day ___ hr. ___ min.

9. Birthplace N. Carolina (Town, county, and state)

10. Usual Occupation Rope Stayer

11. Industry or business Glenn L. Martin Co.

FATHER 12. Name Wesley Kenney

13. Birthplace Texas.

MOTHER 14. Maiden Name Carolina Strut

15. Birthplace N. Carolina

16 (a) Informant Paul Strut

(b) Address 1202 N. Bolling Rd. Balto 20

17 (a) Trans. (Burial, cremation, or removal) (b) Date thereof Oct. 19-44 (month) (day) (year)

(c) Cemetery or crematory

Location Buladen, N. C.

18 (a) Funeral director John J. Connelly

(b) Address 4146 Eastern Ave. Balto

19 (a) OCT 19 1944 (Date filed by registrar) (b) Huntington for Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1944, at 3:15 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial Hemorrhage.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-14-44 at Middle River Rd. 11 A.M. intersection of M.

(b) Where did injury occur? Company Roof.

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.

(d) Means of injury Was driving auto and struck by truck (Connecting rod)

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.

Date signed October 19, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the

G21750

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 178c

Registered No. G21750

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 S. Paca Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 S. Paca Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas S. Newhouse

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of ~~husband~~ or wife not living

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace Romney, W. Va (Town, county, and state)
10. Usual Occupation Blacksmith
11. Industry or business

FATHER
12. Name Geo. R. Newhouse
13. Birthplace Romney W. Va

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Ralph N. Guthrie
(b) Address Romney, W Va

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 21st 1944 (month) (day) (year)
(c) Cemetery or crematory Indian Mound Mem. Park
Location Romney W. Va.

18 (a) Funeral director Charles F. Dill
(b) Address 1501 E. Fort Ave.

19 (a) OCT 20 1944 (Date received by registrar) (b) Huntington, W. Va.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1944, at 11:30 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon Monoxide Poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-18-44 10:15 A. M.
(b) Where did injury occur? 917 S. Paca Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Accidental carbon monoxide Poisoning Kitchen gas stove

23. Signature J. A. Wolfenstein M.D. Medical Examiner.
Date signed October 19, 1944

G21751

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21751

CERTIFICATE OF DEATH 518

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 McAleer Court St. Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. da. How long in U. S. If of foreign birth? yrs. mos. da.

2. FULL NAME Charles J. Frampton

If U. S. Veteran specify WAR

(a) Residence: No. 939 McAleer Court St. Ward. 10-2

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, year) Feb 5th 1879

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	8	12	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Barber

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md.

FATHER

13. NAME Charles W. Frampton

14. BIRTHPLACE (city or town) (State or country) Balto. Md.

MOTHER

15. MAIDEN NAME Charlotte J. Bucher

16. BIRTHPLACE (city or town) (State or country) Balto. Md.

17. INFORMANT Mrs Emma Wilson

(Address) 939 McAleer Court

18. BURIAL, CREMATION OR REMOVAL.

Place Oak Lawn Date 10/21 19 44

19. UNDERTAKER William Cook Inc

(Address) 1217 St. Paul St

20. FILED OCT 20 1944 19

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 17th 1944

22. I HEREBY CERTIFY, That I attended deceased from July 10 1944 to Oct 17 1944

I last saw him alive on Oct 17 1944 Death is said to have occurred on the date stated above, at 4:30 P.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of Prostate	
Other contributory causes of importance:	

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Physical Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No If so, specify

(Signed) A. G. Hamalian M. D.

(Address) 733 Lanvale St

N. B.—WRITE PLAINLY, with ink. USE NO ABBREVIATIONS. If UNKNOWN, STATE SO. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

VS 2

Harold J. Williams, M.D.

G21752

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21752

CERTIFICATE OF DEATH

183a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Devonshire Drive Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

If U. S. Veteran Specify WAR

2. FULL NAME William L Howard 27-20

(a) Residence: No. 3302 Devonshire Drive St., Ward

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. Color or Race: White

5. Single, Married, Widowed, or Divorced (write the word): Widower

6a. If married, widowed, or divorced: HUSBAND of (or) WIFE of: Martha

6. DATE OF BIRTH (month, day, year): Dec 5 1871

7. AGE: Years 72 | Months 10 | Days 14 | If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.: Retired Police Officer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): Elkton Md

FATHER

13. NAME: Richard T Howard

14. BIRTHPLACE (city or town) (State or country): Md

MOTHER

15. MAIDEN NAME: Emma Hof

16. BIRTHPLACE (city or town) (State or country): Md

17. INFORMANT: Edward L Howard

(Address) 3302 Devonshire Drive

18. BURIAL, CREMATION, OR REMOVAL

Place: London Park Date: 10/28, 1944

19. UNDERTAKER: William Cook Jr

(Address) 1219 E Oliver St

20. FILED OCT 20 1944 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year): Oct 19, 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1944 to October 19, 1944

I last saw him alive on October 8, 1944. Death is said to have occurred on the date stated above, at 3:45 P.M.

The principal cause of death and related causes of importance were as follows:

Recurrent Cerebral Apoplexy — Date of onset 10-3-44

Other contributory causes of importance:

Arterio-Sclerosis with Hypertension. — 9

Was an operation performed? No Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Maurice E. Hamer M. D.

(Address) 3300 W. North Ave.

N. B.—WRITE PLAINLY. ... information should be carefully supplied. ... state CAUSE OF DEATH in plain terms, ... OCCUPATION is very important. See Instructions on back of certificate.

VS 3

HEALTH DEPARTMENT—CITY OF BALTIMORE G21753

1753

CERTIFICATE OF DEATH 183a

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 E Hamsutta St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME William T. Price

If U. S. Veteran specify WAR

(a) Residence: No. 29 E Hamsutta St., Ward. 23-2

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6. DATE OF BIRTH (month, day, year) July 17, 1870

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	3	2	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Painter

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Self

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Talbot Md

FATHER

13. NAME William T. Price

14. BIRTHPLACE (city or town) (State or country) Talbot Co Md

MOTHER

15. MAIDEN NAME Rebecca Price

16. BIRTHPLACE (city or town) (State or country) Md

17. INFORMANT Magdalene Price

(Address) Towsons Md

18. BURIAL, CREMATION, OR REMOVAL

Place Glen Haven Date 10/21, 1944

19. UNDERTAKER William Cook Jr

(Address) 1214 E Fort Ave

20. DATE RECEIVED OCT 20 1944 Hunting for Williams M.D.

(Registrar)

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 19, 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct.17/44 19 to Oct.19/44. 19

I last saw him alive on Oct.18/44. 19 Death is said to have occurred on the date stated above, at 34 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cerebral Hemorrhage	Oct.16/44.
Other contributory causes of importance:	
Arterio-Sclerosis.	Unknown.

Was an operation performed? No. Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? None. Was there an autopsy? No.

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No.

(Signed) Harry Mc to Cook M.D.

(Address) 633 Towsons.

VS 2

WHITE PRINTED ON BOTH SIDES. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G21754

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21754 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Use full name of person or street address. Do not use ditto marks. Be sure to answer each question. If unknown or if the question is not applicable, write the word "unknown" or the abbreviation "N. A." Do not omit any item if you can obtain the information. Do not write the causes of death clearly and legibly. Physicians: please write the exact age in especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2579 W. Fayette St.
(c) Hospital or institution —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 yrs 2
(e) Length of stay in Baltimore (yrs., mos., or days) Always

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2579 W. Fayette St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME William F. Titus

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Margaret Titus

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 3-1871

8. AGE: Years 73 | Months 4 | Days 15 | If less than one day — hr. — min.

9. Birthplace Trenton N. J.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Wm Titus
13. Birthplace N. J.

MOTHER
14. Maiden Name —
15. Birthplace N. J.

16 (a) Informant Mrs Adele T. Titus
(b) Address 2571 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director J. A. Weyforth & Son
(b) Address 850 W. Baltimore St.

19 (a) 10-20-1944 (Date received by registrar) (b) Livingston Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18th 1944, at 9a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1935 to Oct 18 1944 and that I last saw him alive on Oct 17 1944

	Duration
Immediate cause of death Myocardial failure from arterio sclerotic heart disease	?
Due to Generalized arterio sclerosis	?
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? —
(Specify type of place)
(e) Means of injury —

23. Signature Livingston D. Williams M. D.

Address 64 S. Fulton Ave Date signed 10-19-44

VS 180

G21755

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21755

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
Since 11:00 A.M. 10/16/44
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 943 Booth Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME NIMROD WESTCOTT (REPORTED TO CORONER)

3 (b) If veteran, name war: World's War #1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Bright Helms
6 (c) If alive, give age - years
7. Birth date of deceased (mo., day, yr.) 5/28/1895
8. AGE: Years 49 | Months 4 | Days 18 | If less than one day hr. min.
9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Garage Keeper
11. Industry or business -

FATHER
12. Name Unk.
13. Birthplace

MOTHER
14. Maiden Name Unk.
15. Birthplace

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1944 (month) (day) (year)
(c) Cemetery or crematory Balto. Nat'l Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laura V. Hudson
(b) Address 1631 Druid Hill Ave.

19 (a) Date filed OCT 20 1944 (b) Registrar Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION P.

20. DATE OF DEATH October 16, 1944, at 7:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16, 1944 to Oct. 16, 1944, and that I last saw him alive on Oct. 16, 1944.

	Duration
Immediate cause of death: Large cerebral hemorrhage destroying most of right occipital lobe of brain.	Same day as death.
Due to: Generalized arteriosclerosis with marked coronary sclerosis and nephrosclerosis.	Unk.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]
Address Baltimore, Md. Date signed 10/17/4 M.D.

Va-14581

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

21756

TN. 90118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1600a

G21756

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1023 N. Caroline St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Thomas (Gertrude

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	N. B

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6th, 1944

8. AGE: Years | Months | Days 7 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name James Thomas
13. Birthplace Maryland

MOTHER
14. Maiden Name Gertrude Frazier
15. Birthplace Washington D. C.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Cremated 9am (b) Date thereof 10-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B. C. Hospital Crematory
Location 4940 Eastern Ave.

18 (a) Funeral director
(b) Address

19 OCT 20 1944 (b) Hunting for Williams M.D.
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 10-13, 1944, at 6.55 A.M. P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/6 1944, to 10/13 1944, and that I last saw him alive on 10/12 1944

Immediate cause of death	Duration
Intra-cranial Hemorrhage.	7 Days
Due to Labor	
Due to Prematurity	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. McDonald Jr M. D.

Address Date signed 10-13-44

VE 150

G21757

AB-90123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 160a

Registered No. G21757

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 401 E. 23rd, St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Mills

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October -7-1944

8. AGE: Years	Months	Days	If less than one day
			5 hrs. min.

9. Birthplace Baltimore-Md.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name William Chambers
13. Birthplace Va.

MOTHER
14. Maiden Name Catherine Mills
15. Birthplace Md.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Cremated 9am (b) Date thereof 10-16-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory B.C.H. Crematory
Location Baltimore City Hospitals

18 (a) Funeral director
(b) Address

19 OCT 20 1944 (b) Huntington Williams M.D.
(Date received by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-7 1944, at 9.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1944, to 10-7 1944, and that I last saw him alive on 10-7 1944.

Immediate cause of death: (a) INTRA CRANIAL Hemorrhage — Duration 5 hrs.
Due to: (b) BIRTH INJURY
Due to: (c)
Other Conditions PREMATURITY
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Berry, Jr. M.D.
M. D.
Address Balto City Hosp Date signed 10-9-44

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21758

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21758 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3334 E Baltimore St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-6-10
(e) Length of stay in Baltimore (yrs., mos., or days) 57yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3334 E Baltimore St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Peter H Kern

3 (b) If veteran, name war: 1st World War
3 (c) Social Security Account No.:
4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dora Kern
6 (c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) Jan 26 1887
8. AGE: Years 57 Months 9 Days 27 If less than one day 23 hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Guard
11. Industry or business Standard Oil

FATHER
12. Name Walter Kern
13. Birthplace Baltimore

MOTHER
14. Maiden Name Don't Know
15. Birthplace Baltimore

16 (a) Informant Mrs Dora Kern
(b) Address 3334 E Baltimore St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location City
18 (a) Funeral director Ulrich Funeral Home
(b) Address 2008 Aliceanna
19 (a) (Date rec'd by registrar) (b) Huntington Williams Registrar

OCT 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1944, at 9:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Oct 18 1944, and that I last saw him alive on Oct 15 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	10/17/44
Due to: Chr. Myocarditis	5/.44
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature William J Roemer M. D.
Address 801 N Carrollton Date signed 10/19/44

G21759

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21759 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 N Milton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7-2
(e) Length of stay in Baltimore (yrs., mos., or days) 87 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 N Milton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob W. Busch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Margaret Busch
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/4/1857

8. AGE: Years 87 | Months 8 | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace Baltimore
(Town, county and state)

10. Usual Occupation Night Watchman

11. Industry or business

FATHER 12. Name John Busch

13. Birthplace Baltimore

MOTHER 14. Maiden Name Ellen Collins

15. Birthplace Ireland

16 (a) Informant Mrs Elizabeth Smith

(b) Address 815 N Milton Ave

17 (a) Burial (b) Date thereof Oct 23
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Oak Lawn Cem

Location City

18 (a) Funeral director Ullrich Funeral Home

(b) Address 2008 Allendale Rd

19 (a) (b) Huntington Witness
(Date received by registrar) OCT 20 1944

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE NO ENTRIES IN SPACES RESERVED FOR BOARD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 16 1944 at 9 30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Oct 18 1944. and that I last saw h[illegible] alive on Oct 18 1944.

Immediate cause of death Coronary Thrombosis — Duration 2 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Joseph PaKorny MD M. D.
Address 2200 E Madison St Date signed 10/19/44

G21760

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1862

G21760
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. To correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Elliott Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Adamski

3 (b) If veteran, name war —

3 (c) Social Security Account No. 218-14-9996

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna (Adamski)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 17, 1885

8. AGE: Years	Months	Days	If less than one day
59	—	—	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name Paul Adamski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Wnaczewicz
15. Birthplace Poland

16 (a) Informant Mrs. Marie Dartpean
(b) Address 427 N. Rose Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Nr. Carnel Road

18 (a) Funeral director M. J. Sadowski & Son
(b) Address 1896 Eastern Ave.

19 (a) OCT 20 1944 (Date rec'd by registrar) (b) Hunting for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1944, at 8:45 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock
Fracture of pelvis.
Fracture of left wrist.
Due to
Other Conditions Internal Hemorrhage
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-17-44 at 5:45 P.M.
(b) Where did injury occur? 1013 S. Streeper Street
(c) Did injury occur at home, on farm, industrial place, in public place? Public Place. While at work? Yes.
(d) Means of injury Fell off of Roof.

23. Signature Howard J. Bruns M.D. Medical Examiner.
Date signed Oct. 19, 1944.

G21761

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G21761
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 Gilbert St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 621 Gilbert Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Burrow

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1867

8. AGE: Years	Months	Days	If less than one day
77	3	14	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Sexton Church
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Mary Carter
(b) Address 1625 N. Calhoun

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location Balto. County Md.

18 (a) Funeral director William A. Jackson
(b) Address 916 Pennsylvania Ave.

19 (a) OCT 20 1944 (b) Entered for Williams, M.E. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1944; at 4:30 P. M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Chronic Nephritis.
Parenchymatous
Due to Enterocolitis

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
(For) Medical Examiner.
Date signed October 19, 1944

VS 151

G21762

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21762 Registered No. 171a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1516
(c) Hospital or institution West Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1649 Poplar Grove (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lina Jachantra

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30, 1864

8. AGE: Years 80 | Months 3 | Days 19 | If less than one day: hr. min. 1860

9. Birthplace Switzerland (Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name Christina Wirz
13. Birthplace Switzerland

MOTHER
14. Maiden Name Oerana Schoemaker
15. Birthplace Switzerland

16 (a) Informant Arnold J. Jachantra
(b) Address 2201 Elmira Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)
(c) Cemetery or crematory
Location Cambridge Md

18 (a) Funeral director John O Mitchell
(b) Address 1900 Eutaw Pl.

19 (a) OCT 20 1944 (Date rec'd by registrar) Huntington Williamsville, N.B.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to h[illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed head and body

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 19, 1944 1:45 P.M.
(b) Where did injury occur? North Ave & Whitmore St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by streetcar

23. Signature Robert Lee Bratton M.D. Medical Examiner.
Date signed 10-20-44

WIBER

G21763 BALTIMORE CITY HEALTH DEPARTMENT G21763

462531 CERTIFICATE OF DEATH 1937 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Oakdale Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary K. Wiber
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 4 1897
8. AGE: Years 47 Months 3 Days 14 If less than one day hr. min.
9. Birthplace 7-4-97 Balto Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business
FATHER 12. Name Wm. Kendall
13. Birthplace Md
MOTHER 14. Maiden Name Estelle Bowers
15. Birthplace Md
16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md
18 (a) Funeral director Harry H. Armacost
(b) Address 420 Edgewood Ave
19 (a) OCT 20 1944 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1944 at 12 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Oct 18 1944 and that I last saw her alive on Oct 18 1944

Immediate cause of death Cerebral Hemorrhage — Duration 5 min

Due to Hypertensive Cardiovascular disease + Arteriosclerosis, generalized — Duration 5 yrs

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Laurence Dechert M.D.
Address Johns Hopkins Hosp Date signed 10/18/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

VS 150 Huntington Williams, 1st Dep.

G21764

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21764

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3530 E.FAIRMOUNT AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6 4
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3530 E.FAIRMOUNT AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME HARRY L.FISCHER (HENRY L.FISHER)

3 (b) If veteran, name war: W.W.# 1
3 (c) Social Security Account No. 212 07 5115

4. Sex: MALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: MARRIED
6 (b) Name of husband or wife: MARGARET FISCHER
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG.16 1889

8. AGE: Years	Months	Days	If less than one day
55	2	2	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation PRESSMAN
11. Industry or business BALTO.NEWS POST

FATHER
12. Name HENRY FISCHER
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name LOUISE STUDIE
15. Birthplace BALTO.MD.

16 (a) Informant MARGARET FISCHER(WIFE)
(b) Address 3530 E.FAIRMOUNT AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT.21/44 (month) (day) (year)
(c) Cemetery or crematory US NATIONAL
Location FREDERICK AVE.

18 (a) Funeral director Lilly & Zeeter
(b) Address 403 S.WOLFE ST.

(a) OCT 20 1944 Huntington Williams M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 18 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 6/18 1944 to 10/18 1944, and that I last saw h.. alive on 10/14 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to Coronary Sclerosis - Edema

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. A. Flom
Address 3215 Eastern Av Date signed 10/19/44

Chas. A. Flom

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21765

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G21765 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2606 TALBOT RD.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 53
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EDYTHE MAE DISNEY

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex FEMALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CLAYTON H. DISNEY

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/10/1880

8. AGE: Years 64 | Months 1 | Days 17 | If less than one day hr. min.

9. Birthplace BALTO., MD. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name HARRIS T. BERRY

FATHER 13. Birthplace BALTO. MD.

MOTHER 14. Maiden Name IDA MAE PLETCH

MOTHER 15. Birthplace BALTO., MD.

16 (a) Informant MR. CLAYTON H. DISNEY

(b) Address 2606 Talbot Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/20/44 (month) (day) (year)

(c) Cemetery or crematory WOODLAWN CEM.

Location WOODLAWN, MD.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address BALTO., MD.

OCT 20 1944 (b) (Date filed by registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 17 1944 at 5:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Oct 17 1944 and that I last saw h[illegible] alive on Oct 17 - 1944

Immediate cause of death: Acute Dilitation of Heart — Duration 6 hrs

Due to: Coronary Thrombosis — 2 days

Due to:

Other Conditions: Hypertension — 3 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harlan W. Stroop M. D.

Address 826 N Fulton Ave Date Oct 19 44

G21766

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G21766 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5605 Wayne Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5605 Wayne Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: William H. Stuck

3 (b) If veteran, name war: None

3 (c) Social Security Account No. 212-05-3942

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Grace M. Stuck

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) 8/5/1883

8. AGE: Years 61 | Months 2 | Days 13 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Clerk

11. Industry or business: Gas & Electric Co.

FATHER
12. Name: Stuck
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary E. Callahan
15. Birthplace: Md.

16 (a) Informant: Mrs. Grace M. Stuck
(b) Address: 5605 Wayne Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn
Location: Woodlawn Md.

18 (a) Funeral director: William J. Tickner & Sons
(b) Address: North & Pa. Aves

19 (a) OCT 20 1944 (Date received by registrar) Huntington Wil... Maryland, M.D. (Address) (Signature)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18/44 19 , at 7:55

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944 to Oct 18 1944 and that I last saw him alive on Oct 17 1944

Immediate cause of death: Hypertrophy of Heart Sclerosis of Coronary Arteries

Due to: Heart Lesion (Mitral Valve)

Due to:

Other Conditions: C.H.F. & Cirrhosis of Liver

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration: 3 months 4 yrs

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature: Marion W. Stuck
Address: 5624 Fullerton Ave. Signed 10-19-44

G21767

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21767 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3339 Pama St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A Cromwell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	widower

6 (b) Name of husband or wife Emma L. Cromwell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1865

8. AGE: Years	Months	Days	If less than one day
78 79	10	4	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Roofer.

FATHER
12. Name George Cromwell
13. Birthplace Md

MOTHER
14. Maiden Name Margaret F. Dolan
15. Birthplace Md.

16 (a) Informant Ruth F. Wiseman.
(b) Address 1619 Rutland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20/44 (month) (day) (year)
(c) Cemetery or crematory Jerusalem Church
Location Harford Co Md

18 (a) Funeral director C. Brunswick O'Donovan
(b) Address 3615-17 Baltimore

OCT 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1944, at 7:15 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 10-20-44

G21768

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21768 Registered No. 186a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 10/9/44 7:30 PM
(e) Length of stay in Baltimore (yrs., mos., or days) Since 10/9/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Oak Grove
(If outside city or town limits, write RURAL and give town)
(d) Street No. -
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME STAPLES, Herbert

3 (b) If veteran, name war	3 (c) Social Security Account No.
-	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 31, 1906

8. AGE: Years	Months	Days	If less than one day
38	4	18	hr. min.

9. Birthplace ? Va.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name Noah Staples
13. Birthplace ? Va.

MOTHER
14. Maiden Name Annie World
15. Birthplace West Miller, Va.

16 (a) Informant Records, U.S. Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Removal (b) Date thereof 10-20-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Oak Grove, Virginia

18 (a) Funeral director Thomas H. Sinclair (Inc)
(b) Address Fullers Burnie, Maryland

OCT 20 1944
(Date received by registrar) Huntington Williams, M.D.

VS 188 Approved: Robert Lee Forbes M.D. File #55997 10/20/44

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Oct. 19, 1944, at 11:22 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 9, 1944, to Oct. 19, 1944, and that I last saw him alive on Oct. 19, 1944.

Immediate cause of death	Duration
Acute empyema of gall bladder; Acute cystitis & pyelitis	
Due to Fracture 4th cervical vertebra with complete severence of cervical spinal cord.	Since 9/29/44
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 9/29/44 - Accidant
(b) Date of occurrence 9/29/44 at M
(c) Where did injury occur? Oak Grove, Va.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Farm While at work? Yes
(Specify type of place)
(e) Means of injury Loading hay, fork fell & knocked him off wagon.
23. Signature William M. Crawford MD
Address Baltimore, Md Rte. 225. Date signed 10/19/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G21769

G21769

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G21769

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 Maund Ave, Brooklyn
(c) Hospital or institution:
Sa. Balto GEN Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town BALTO. 5-4
(If outside city or town limits, write RURAL and give town)
(d) Street No. 619 Maund Ave. Brooklyn (If rural give location)
(e) Citizen of foreign country? ——— (Yes or No)
If yes, name country ———

3 (a) FULL NAME William Budesheim

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife ———

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) December 25/187[illegible]

8. AGE: Years 67 | Months 9 | Days 24 | If less than one day ——— hr. ——— min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Lumber planer

11. Industry or business

FATHER 12. Name John Budesheim
13. Birthplace Germany

MOTHER 14. Maiden Name Louise Bedel
15. Birthplace Maryland

16 (a) Informant ALICE ANDERSON
(b) Address Same.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location A. G. Co., Md.

18 (a) Funeral director John F. Dempsey, Inc.
(b) Address 715 Light St.

19 (a) ——— (b) ———
(Undertaker's registration) Registrar

OCT 20 1944

Thurlington Hall

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-1944 at 6 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 12 1944 to Octo. 19 1944 and that I last saw him alive on Oct. 19-1944.

Immediate cause of death: Coronary Thrombosis — Duration

Due to ———

Due to ———

Other Conditions Hypertension Cardio Vascular Renal
(Include pregnancy within 3 months of death)

Date of operation ———

Major findings of operation: ———

of autopsy ———

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ———
(b) Date of occurrence ——— at ——— M
(c) Where did injury occur? ——— (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ——— While at work? ———
(Specify type of place)
(e) Means of injury ———

23. Signature Chas. R. Macdonald M. D.
Address 1213 Light St Date signed Oct 19 1944

G21770 BALTIMORE CITY HEALTH DEPARTMENT G21770

CERTIFICATE OF DEATH 182a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 429 Pittman Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James A. Kelley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/11/44

8. AGE: Years | Months: 3 | Days: 7 | If less than one day: hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name

13. Birthplace

MOTHER
14. Maiden Name Anna E. Kelley

15. Birthplace Baltimore, Md.

16 (a) Informant Anna E. Kelley

(b) Address 429 Pittman Place

17 (a) Burial (b) Date thereof Oct 21/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mount Olivet

Location Frederick Rd

18 (a) Funeral director John F. Denny Inc

(b) Address 715 Light St

19 (a) OCT 20 1944 Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1944, at 2 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suffocation by bedclothes

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-18-44 at 12:30 P. M.
(b) Where did injury occur? 429 Pittman Place
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No.
(d) Means of injury Suffocation by bedclothes.

23. Signature H. H. Weldenmeyer M.D.
Medical Examiner.
Date signed October 19, 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21771 (typed) G21771 (printed) 937 — Registered No. G21771

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3007 O'Donnell Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3007 O'Donnell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME JOHN HENRY LEDSINGER

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Elizabeth Stockwish
6 (c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Mar. 15, 1869

8. AGE: Years	Months	Days	If less than one day
75	7	2	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Penna. R.R. Ret. 1936

FATHER
12. Name John H. Ledsinger
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Martha Collins
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Elizabeth Ledsinger
(b) Address 3007 O'Donnell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Baltimore, Md.

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

19 OCT 20 1944 (b) Date received by Registrar — Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 17, 1944 at 8.15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 19 to Oct 17 1944 and that I last saw h[illegible] alive on Oct 17 1944

Immediate cause of death	Duration
Arteriosclerotic Cardiovascular Disease.	
Due to Acute Coronary Thrombosis	Sept 25/44
Due to Acute Coronary Occlusion	Oct. 17/44
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Huntington Williams M.D.
Address 842 S. East Ave. Date signed 6/10/44

VS 150

G21772

JO #90253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a

G21772 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1103 Race St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME: Frank Belton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Alberta
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 16, 1884

8. AGE: Years	Months	Days	If less than one day
59	10	-2-	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Frank Belton
13. Birthplace South Carolina

MOTHER
14. Maiden Name Susie Harris
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/22/44 (month) (day) (year)
(c) Cemetery or crematory Camden
Location South Carolina

18 (a) Funeral director Isaac L. Brown & Son
(b) Address 844 Montgomery St

OCT 20 1944 (Date rec'd by registrar)

(b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1944, at 11:42 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 17, 1944, to Oct. 18, 1944, and that I last saw him alive on Oct. 18, 1944.

Immediate cause of death	Duration
Uremia ?	1 wk.
Due to Urinary Obstruction	
Due to Benign Prostatic Hypertrophy	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Williams
Address Balt City Hosp Date signed 10-19-44 M. D.

G21773

JO #90209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

Registered No. G21773

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write the word "unknown" if you cannot obtain the correct answer. Do not leave any blank unless you are sure it is unimportant. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 145 W. Montgomery St.

(If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country.....

3 (a) FULL NAME M

Laura Hill

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Willie (d)

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 19, 1905

8. AGE: Years 39 | Months -1- | Days -0- | If less than one day ..... hr. ..... min.

9. Birthplace Maryland

(Town, county, and state)

10. Usual Occupation.....

11. Industry or business.....

FATHER

12. Name Augustus Martin

13. Birthplace Maryland

MOTHER

14. Maiden Name Estelle Floyd

15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (b) Date thereof 10/22/44

(Burial, cremation, or Removal) (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location a. a. Co. Md

18 (a) Funeral director Isaiah J. Brown Sr.

(b) Address 1054 W Montgomery St

19 OCT 20 1944 (b) Huntington Williams, M.D.

(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1944, at 6:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 13, 1944 to Oct. 19, 1944 and that I last saw h er alive on Oct. 19, 1944

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary Tuberculosis Ulcerative	1 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Confirmatory

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?.....

(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....

(Specify type of place)

(e) Means of injury.....

23. Signature Harold Dillon M. D.

Address Balto City Hosp Date signed 10/20/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21774 (typed) G21774 (Registered No.)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring
(c) Hospital or institution: Levindale Hebrew Home & Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 45 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mr. Israel Hazanoff (CHASANOFF)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widowed
6 (b) Name of husband or wife Carl –
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1862

8. AGE: Years 82 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation Ret
11. Industry or business

FATHER 12. Name Simon –
13. Birthplace Russia

MOTHER 14. Maiden Name –
15. Birthplace Russia

16 (a) Informant Dr. I. Riegel
(b) Address 2309 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levine Inc
(b) Address 1739 E. Balto. St

19 (a) (Date received by registrar) (b) Huntington Williams, M.D. Registrar

OCT 23 1944

VS-128

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1944, at 10.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 5-30 1937, to 10-20 1944, and that I last saw him alive on 10-20 1944

Immediate cause of death Cer. card. vas. disease Hypertension, Arterio sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Edmund Levin, M.D.
Address Levindale Date signed 10/24/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21775

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G21775 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1714 E Monument St
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2101 Division St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Aaron Lander

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Minnie Lander

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 68 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Rt

11. Industry or business

FATHER 12. Name David Lander
13. Birthplace Russia

MOTHER 14. Maiden Name Esther –
15. Birthplace Russia

16 (a) Informant David Lander
(b) Address 1500 Braddish Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-20-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jos Levin Inc
(b) Address 1439 E. Balto St

OCT 20 1944 (Date rec'd by Registrar) Huntington Williams Mgr

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1944, at 2:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1944 to 10/20 1944, and that I last saw h[illegible] alive on 10/20 1944.

Immediate cause of death: Acute coronary failure — Duration

Due to: Generalized arteriosclerosis, — Duration

Due to: — Duration over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dr. I. M. Greenberg

Address Sinai Hospital Date signed 10/20/44 D.

G21776

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G21776

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene St
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 612 N. Carrollton Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cora Hedgeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	Married

6 (b) Name of husband or wife Thomas Hedgeman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 1894

8. AGE: Years	Months	Days	If less than one day
50	2		hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Thompson
13. Birthplace Va

MOTHER
14. Maiden Name unobtainable
15. Birthplace

16 (a) Informant Husband
(b) Address 428 N. Calhoun St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)
(c) Cemetery or crematory Laurel
Location Laurel, Va

18 (a) Funeral director Ged. G. Nelson
(b) Address 1303 Riesselman St

19 (a) OCT 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150 To be approved by Medical Examiner 10/20/44

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1944, at 10:55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16, 1944, to Oct 19 1944, and that I last saw h.e.y alive on Oct 19 1944.

Immediate cause of death Resp. failure on operating table

Due to Cardiac failure

Due to Syphilis dad Carcinoma of ovary

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/19/44

Major findings of operation: Pseudo myxoma cystadenoma ovary - malignant changes

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Millard Ingleby Jr M.D.
Address Nurses Registry Date signed 10/20/44

Approved: Edward Le Fevre M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully reported. Any correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G21777

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 98

Registered No. G21777

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd + Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1215 Bolton St.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George Hamilton Wade.

3 (b) If veteran, name war ?
3 (c) Social Security Account No. ?

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Widower
6 (b) Name of husband or wife: Anna McDaniel
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Apr. 17, 1870
8. AGE: Years 74 | Months 6 | Days 23 | If less than one day hr. min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Pharmacist
11. Industry or business

FATHER
12. Name Hamilton D Wade
13. Birthplace Va.

MOTHER
14. Maiden Name Mary Earhart
15. Birthplace Va.

16 (a) Informant Julia B. Robinson
(b) Address 1205 Bolton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director John O. Mitchell Bros
(b) Address 1900 Eutaw Place

19 OCT 20 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1944 at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 4-26 1944 to 10-20 1944 and that I last saw h.im alive on 10-20 1944

	Duration
Immediate cause of death Cardio-respiratory failure.	
Due to Pneumonia — Left Lg.	6 days
Due to A-S Gangrene of Leg.	4 years.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-2-44
Major findings of operation: Gangrene, A-S basis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10-20-44

G21778

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21778

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Tudor Arms Apartments
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Tudor Arms Apartments (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Anthony Bonn

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Grace Eareckson
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1875

8. AGE: Years 69 | Months 2 | Days 17 | If less than one day: hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation B & O RR

11. Industry or business Executive accountant

FATHER
12. Name Anthony S. Bonn
13. Birthplace Baltimore

MOTHER
14. Maiden Name Martha Ewing
15. Birthplace W. Va.

16 (a) Informant Mrs. Grace E. Bonn
(b) Address Tudor Arms Apts.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 20 1944 (Date rec'd by registrar) (b) Huntington, W. Va. (Burial, cremation, or removal) MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19 1944, at 2 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1941 to Oct 19 1944, and that I last saw living on Oct 19 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	2 wk
Due to: Cerebro-Sclerosis	Indefinite
Due to: Hypertension	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. A. Woody
Address 1403 Park Ave. Date signed 10/19/44

G21779

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1628

Registered No. G21779

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2435 Maryland Ave.
(c) Hospital or institution:
none
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2435 Maryland Ave.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H. Settle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 3, 1868

8. AGE: Years 76 | Months 2 | Days 15 | If less than one day ____ hr. ____ min.

9. Birthplace Cecil County, Md.
(Town, county, and state)

10. Usual Occupation retired

11. Industry or business

FATHER
12. Name John S. Settle
13. Birthplace England

MOTHER
14. Maiden Name Alice Booth
15. Birthplace England

16 (a) Informant W. Booth Settle
(b) Address 633 Equitable Bldg.

17 (a) Burial (b) Date thereof 10/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery ~~crematory~~ Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director John O. Mitchell & Sons, Inc.
(b) Address 1900 Eutaw Place

19 (a) OCT 20 1944 (b) Huntington Hill
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 19 44 at 12 ~~P~~ M

21. I certify that death occurred on the date above stated; that I attended deceased from July 18 1944 to Oct 18 1944, and that I last saw her alive on 10/17/44 19

Immediate cause of death: Cardiac failure — Duration

Due to

Due to — Duration: over

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm B Steele M. D.
Address 2435 Maryland Ave. Date signed 10/19/44

G21780

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21780
Registered No.

131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 333 S Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 333 S. Gilmor St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie D. Ault.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: late Harry E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 31, 1877

8. AGE: Years 67 | Months 8 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Henry Fuchs
13. Birthplace Germany

MOTHER: 14. Maiden Name Dora Wolf
15. Birthplace Germany

16 (a) Informant Arthur K. Ault.
(b) Address 333 S. Gilmor St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10.21.44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry H. Witzke
(b) Address 1016 Annondale Ave.

19 (a) (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

OCT 20 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1944, at 2:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1944, to Oct. 17 1944, and that I last saw him alive on Oct. 16 1944.

Immediate cause of death: Uremia Chronic Glomerulo Nephritis

Due to: Arteriosclerosis

Due to: Chron. Intra. Syphilis

Duration

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. G. Moore M. D.

Address 56 Cathedral Date signed 10.18.44

G21781

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1190

G21781 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1725 Leman St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) ✓
If yes, name country

3 (a) FULL NAME Earl Gerlach

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1944

8. AGE: Years | Months 4 | Days 10 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm H. Gerlack
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Elsie K. Myers
15. Birthplace Balto, Md

16 (a) Informant Wm H Gerlack
(b) Address 1725 Lemmon St

17 (a) Burial (b) Date thereof 10/31/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Western Cemetery
Location Edmondson Ave & Smallwood

18 (a) Funeral director Thos. J. Kenny
(b) Address Hollins & Gilmor, Md

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 20 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1944 at 8 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18 1944 to 10/18 1944 and that I last saw h.. alive on 10/18 1944

Immediate cause of death Non-specific diarrhea — Duration

Due to

Due to

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Earl Myers
Address Franklin Sq. Hosp. Date signed M. 10 D. 18/44

G21782 ✓ G21782

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4310 Evans Chapel Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ✓
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and name town)
(d) Street No. 4310 Evans Chapel Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Caroline Edrington

3 (b) If veteran, name war — 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles M. Edrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 14-1879

8. AGE: Years 64 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (City, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Henry Fuhrman
13. Birthplace Germany

MOTHER
14. Maiden Name Martha Hampler
15. Birthplace Maryland

16 (a) Informant Charles M. Edrington
(b) Address 4310 Evans Chapel Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 21-1944 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Fpalls Road

19 (a) OCT 20 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1944 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1939 to Oct. 18 1944 and that I last saw h alive on 19

Immediate cause of death	Duration
Coronary Occlusion	1 hour
Due to Hypertension	5 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sherman Mains M.D.
Address 2601 Manhattan Ave Date signed 10/18/44

For [redacted] B. McKelvey, Raymond J. Hansen, M.D.

G21783

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161C

Registered No. G21783

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1807 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Earl (Kelley) Keeley

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Blk | 6 (a) Single, married, widowed, or divorced. child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-11-44

8. AGE: Years | Months | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Keeley
13. Birthplace Md.

MOTHER
14. Maiden Name Elizabeth Williams
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location JOHNS HOPKINS HOSPITAL STATION OCT 20 1944

18 (a) Funeral director Commissioner of
(b) Address

19 OCT 20 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14- 1944, at 2.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14- 1944, to 10-14- 1944, and that I last saw him alive on 10-14- 1944

Immediate cause of death	Duration
Hemorrhage	
Due to Hemorrhage Disease of newborn	
Due to acute asphyxia of newborn	
Other Conditions Digitalis intoxication?	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C Govan Jr. M. D.

Address Date signed

2248

G21784

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21784

CERTIFICATE OF DEATH 167

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 915 N Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Evelyn F Acker

3 (b) If veteran, name war: W
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30 1919

8. AGE: Years	Months	Days	If less than one day
25 yrs	2	20	hr. min.

9. Birthplace Ostenburg Pa (Town, county, and state)
10. Usual Occupation Electrical Worker
11. Industry or business Fairfield-Bethlehem

FATHER
12. Name Clyde B Acker
13. Birthplace Pa

MOTHER
14. Maiden Name Myrtle Mock
15. Birthplace Pa

16 (a) Informant Clyde B Acker
(b) Address 3510 Yale St Balto 20 Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/21/44 (month) (day) (year)
(c) Cemetery or crematory Zion Church
Location Dundalk Md

18 (a) Funeral director J M Cohen Inc
(b) Address 217 E Lexington St

19 (a) OCT 20 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1944 at 5:20 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Stab wound of chest

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 20 1944 at 5:20 A.M.
(b) Where did injury occur? St Paul & Read Sts
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Stabbed

23. Signature Robert Lee Gutman M.D. Medical Examiner.
Date signed Oct. 20 1944

G21735

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54a

G21735 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert St.
(c) Hospital or institution: Union Memorial Hospital.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 721 Newington Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Daisy E Richey

3 (b) If veteran, name war

3 (c) Social Security Account No. 522-09-2445

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married.

6 (b) Name of husband or wife Mr. Marvin E. Richey
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) Sept 23, 1906

8. AGE: Years	Months	Days	If less than one day
38	0	27	hr. min.

9. Birthplace Ky. (Irvin)
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Lewis B. Cole.
13. Birthplace Irvin, Ky.

MOTHER
14. Maiden Name Effie Schriver
15. Birthplace Ky. (Irvin)

16 (a) Informant Mr. Marvin E. Richey
(b) Address 721 Newington Ave.

17 (a) Removal (b) Date thereof 10/20/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Colorado Springs, Col.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) OCT 20 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1944 at 7:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-13 1944 to 10-20 1944 and that I last saw her alive on 10-20 1944.

Immediate cause of death	Duration
Cardio-resp failure.	
Due to Increased intracranial pressure.	10 days.
Due to Glioma of left temporal lobe of brain.	4 yrs.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-16-44
Major findings of operation: Glioma of left fronto-temporal region.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Stephen J VanLill jr M. D.
Address Union Memorial Hosp Date signed 10-20-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21786

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93a

G21786 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 W. Pratt St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 W. Pratt St. (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jane Betts

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: William M. Betts
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 23, 1861

8. AGE: Years 82 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Michael Dougherty
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Gilson
15. Birthplace Ireland

16 (a) Informant Mrs. Helen Madden
(b) Address 1735 W. Pratt Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director George H. Schwartz
(b) Address 2101 Fredrick Ave

19 (a) OCT 20 1944 (Date filed by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1944, at 2:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Oct 18 1944, and that I last saw her alive on Oct 18 1944.

Immediate cause of death: Acute Myocarditis — Duration 2 days
Due to Arteriosclerosis
Due to Senility
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm H Thomson M.D.
Address 401 Edmondson Date signed 10/19/44

G21787

YA-90299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

Registered No. G21787

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Balto. Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3314 Martini Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ida Dodson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Luther

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1881

8. AGE: Years	Months	Days	If less than one day
63	4	26	hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Butler
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS (RECORDS)
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 20 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18 (a) Funeral director Warner E. Pumphrey
(b) Address Silver Spring, Md.

19 OCT 21 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1944 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12:05 AM 10/20 1944 to 7 AM 10/20 1944, and that I last saw h.e.c. alive on 10/20 1944.

Immediate cause of death	Duration
Massive hemoptysis	Instant
Due to Far advanced pulmonary tuberculosis	2 years
Due to	
Other Conditions Generalized arteriosclerosis Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Gibson Parrish M.D.
Address Baltimore City Hosp. Date signed 10/20/44

G21788

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21788 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
Elsinore Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1510 W. Lexington St. 2
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton S. Tyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Laura G. Tyler
6 (c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) May 1876

8. AGE: Years	Months	Days	If less than one day
68	5	-	hr. min.

9. Birthplace Calvert County, Md.
(Town, county, and state)
10. Usual Occupation Retired - Clerk
11. Industry or business

FATHER
12. Name Allen Tyler
13. Birthplace Maryland

MOTHER
14. Maiden Name Alice Yates
15. Birthplace St. Mary's County, Md.

16 (a) Informant Mrs. Laura G. Tyler
(b) Address 1708 Eutaw Place

17 (a) Burial (b) Date thereof Oct. 21, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cemetery
Location Baltimore, Md.

18 (a) Funeral director Miller Lawrence
(b) Address 4516 Liberty Heights Ave. Baltimore, Md.

19 (a) OCT 21 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18 1944, at 9.50P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1934 to Oct. 18 1944
and that I last saw h. im alive on Oct. 1 8 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	9 days
Due to Hypertension	?
Due to	
Other Conditions -	

(Include pregnancy within 3 months of death)
Date of operation -
Major findings of operation: -
of autopsy: -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide -
(b) Date of occurrence - at M
(c) Where did injury occur? -
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury -
23. Signature Morris B. Schreiber M. D.
Address 54 S. Fulton Ave. Date signed 10-19-44

G21789

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46M

G21789 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address [redacted] Ave.
(c) Hospital or institution: South Balto Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 8 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md Tenn. (b) County Baltimore
(c) City or town Dundalk (If outside city or town limits, write RURAL and give town)
(d) Street No. 6903 Bristow Ave Dundalk (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henryetta Leatherwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry Pitt

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4-9-864

8. AGE: Years 80 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace Tenn. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Pitt
13. Birthplace Tenn

MOTHER
14. Maiden Name —
15. Birthplace

16 (a) Informant (Son) Robt. L. Leatherwood
(b) Address

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof 10-24-44 (month) (day) (year)
(c) Cemetery or crematory Covington.
Location Covington Tennessee

18 (a) Funeral director Wesley R. McFarrin,
(b) Address 4114 Dolfield Road.

OCT 21 1944 (Date rec'd by registrar) (b) Registrar

VS 186

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19- 1944, at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14- 1944 to 10-19-1944, and that I last saw h[illegible] alive on 10-19- 1944.

Immediate cause of death — Duration

Generalized arteriosclerosis

Due to Senility

anemia

Due to possible GI malignancy

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operations:

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Ehrlich M. D.
Address 1213 Light St. Date signed 10-20-44

G21790

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1314

Registered No. G21790

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 626 N. Carolina st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give township)
(d) Street No. 626 N. Carolina st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Greenwood

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	Colored	widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name James Defuedene

13. Birthplace Porto Rico

MOTHER 14. Maiden Name Mary Black

15. Birthplace Unknown

16 (a) Informant John H. Greenwood

(b) Address 933 Mason st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 (month) 23 (day) 44 (year)

(c) Cemetery or crematory Mt Calvary

Location Brooklyn, A. A. Co. Md.

18 (a) Funeral director Martha Bailey

(b) Address 142 E. Jefferson st.

19 OCT 21 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19- 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-18- 1944, to 10-19 1944, and that I last saw him alive on 10-16-1944.

Immediate cause of death Cardiac - Renal disease

Due to

Due to

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.

Address Balto. Md. Date signed 10-20-44

G21791

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21791

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 49 N. Caroline Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Rogers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. ?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1901

8. AGE: Years 43 | Months | Days | If less than one day hr. min.

9. Birthplace Ga.
(Town, county, and state)

10. Usual Occupation ?

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) Burial (b) Date thereof 10/21/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location

18 (a) Funeral director Mrs. Ida Bailey
(b) Address 1421 E. Jefferson St.

19 (a) OCT 21 1944 (b) Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 17, 1944, at 7:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
Autopsy, Inspection or Inquiry

IMMEDIATE CAUSE OF DEATH Respiratory Obstruction.

Due to Second and third degree burns.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-17-44 12:17 P. M. 6/5
(b) Where did injury occur? 49 N. Carolina Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Was smoking in bed set room on fire.

23. Signature Harry J. Moseley M.D.
Medical Examiner.
Date signed October 17, 1944.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21792

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G21792
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct as is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 17-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 574 Preston St. W. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David McNeil

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1899

8. AGE: Years	Months	Days	If less than one day
45			hr. min.

9. Birthplace North Carolina (Town, county, and state)

10. Usual Occupation [redacted] Laborer

11. Industry or business

MOTHER / FATHER

12. Name Sam McNeill

13. Birthplace North Carolina

14. Maiden Name Miss Smith

15. Birthplace North Carolina

16 (a) Informant Festus Smith

(b) Address 1711 Riggs Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1944 (month) (day) (year)

(c) Cemetery or crematory Dunn, N. C.

Location [redacted] N. C.

18 (a) Funeral director A. Raleigh

(b) Address 1 Druid Hill Ave.

OCT 21 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 18 1944, at 12 15 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 17 1944 to Oct 18 1944, and that I last saw h/[illegible] alive on Oct 18 1944

Immediate cause of death: Lobar Pneumonia — Duration: 3 wks.

Due to

Due to

Other Conditions: Acute Myocardial Failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H H Bagnall M. D.

Address Provident Hospital Date signed 10/19/44

C21793

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. C21793

Every item of information should be carefully written. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7 Temple St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Allen Clement

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years	Months	Days	If less than one day
50			hr. min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1937 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 718 Druid Hill Ave.

19 (a) OCT 21 1937 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/17 1937, at 12 P M

21. I certify that I took charge of the remains described above, held an Inspection-Autopsy, Inspection or Inquiry and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Chronic Myocardial Degeneration

Due to

Other Conditions Hypertensive CV disease

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Charles J. Robinson M.D. Medical Examiner.
Date signed 10/17/37

G21794

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21794 / 1190

Registered No. G21794

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 hr
(e) Length of stay in Baltimore (yrs., mos., or days) 2 mo

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 N. Oxford St
(If rural give location)
(e) Citizen of foreign country? Not (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Walters

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	B.	S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/11/44

8. AGE: Years	Months	Days	If less than one day
	2	6	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation —
11. Industry or business —

MOTHER / FATHER
12. Name Ernest Walters
13. Birthplace South Carolina
MOTHER
14. Maiden Name Sadie Brockton
15. Birthplace Denmark S.C.

16 (a) Informant Dept. Records
(b) Address

17 (a) Burial (b) Date thereof Oct. 20, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Md.
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave
19 (a) (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 17 1944 at 1030 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1944 to Oct 17 1944 and that I last saw h[illegible] alive on Oct 17 1944

Immediate cause of death Acidosis — Duration 2 Days
Due to Dehydration 9
Due to Diabetes 1 Mo.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Wick M. D.
Address University Hosp Date signed 10-17

G21795

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

~~G21795~~

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 Tyson Street (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME David Allen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Col.

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1881

8. AGE: Years 63 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation paper hanger

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant Elnora Landale
(b) Address 902 Tyson Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Md.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington-Williams Hospitals

OCT 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/18 1944, at 7:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from [illegible] 19 to 19, and that I last saw h alive on 19.

Immediate cause of death Hypernephroma — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. General Hosp. Date signed 10/19/44

G21796

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G21796

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 921 West Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 921 W. Franklin Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carey W. Harney

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1878

8. AGE: Years	Months	Days	If less than one day
66			hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Frank Harney
13. Birthplace N. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Musets Diggs
(b) Address 921 W. Franklin St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-44 (month) (day) (year)
(c) Cemetery or crematory National Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

OCT 21 1944 (Date rec'd by registrar)

(b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 19, 1944, at 5 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 5 1944, to Oct 19 1944, and that I last saw h.. alive on Oct 19 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Julius S. White M. D.
Address 1513 Penna Ave Date signed 10-20-44

G21797

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21797 Registered No. 131a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1645 Covington St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town 1645 Covington St. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1645 Baltimore, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hermine F. Voigt

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Bernhard F. Voigt
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov 8, 1876

8. AGE: Years 67 | Months 11 | Days 12 | If less than one day ____ hr. ____ min.

9. Birthplace HAVERLAU, Germany (Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER 12. Name Heinrich Germer
13. Birthplace Germany

MOTHER 14. Maiden Name Johanna (?)
15. Birthplace Germany

16 (a) Informant Otto Phillip Voigt
(b) Address 1920 Liberty Rd. Dale. 7

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location G. 9. 66

18 (a) Funeral director A. Key and Evans
(b) Address 1424 Eutaw St

19 (a) OCT 21 1944 (Date filed by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20, 1944 at 7:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1944, to 10/20 1944, and that I last saw h— alive on 10/20 1944

	Duration
Immediate cause of death: Myocarditis	
Other Neph. with Hypertension	
Due to: Terminal Bronchopneumonia	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. H. Barranco M. D.
Address 436 E Eutaw Date signed 10/21/44

G21798

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G21798

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 E Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James H. McCullough

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Ida W. McCullough | 6 (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) May 3 - 1877

8. AGE: Years 67 | Months 5 | Days 16 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Balto Trans. Co.

MOTHER / FATHER

12. Name Unknown

13. Birthplace "

14. Maiden Name "

15. Birthplace "

16 (a) Informant Mrs Ida W. McCullough

(b) Address 2405 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)

(c) Cemetery or crematory Oak Lawn

Location Eastern Ave - Balto Md.

18 (a) Funeral director John F. Miller Inc

(b) Address 2415 E Oliver St

19 (a) (b) Registrar

(Date rec'd by Local Reg.)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 19 - 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-14 1944 to 10-19 1944.

and that I last saw h alive on 19

Immediate cause of death Bronchial Pneumonia

Chr Myocarditis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Joseph Tompkins M. D.

Address 441 N. Ellwood Ave Date signed 10/21/44

Huntington Indiana, M.H.

G21799

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1310

Registered No. G21799

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 Mosher St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days) 36 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 703 Mosher St. (If rural give location)
(e) If foreign born, how long in U. S. A.? Life years

3 (a) FULL NAME Eloise Carter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Lyman Carter

6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 2-11-92

8. AGE: Years	Months	Days	If less than one day
52	8	8	hr. min.

9. Birthplace Ft. Mamp'Co., Md. (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Robert Jordan
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Reid
15. Birthplace Md.

16 (a) Informant Lyman Carter
(b) Address 703 Mosher

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto., Md.

18 (a) Funeral director Charles R. Law
(b) Address 802-04 Madison Ave

19 (a) OCT 21 1944 (Date rec'd by registrar) (b) Huntington Williams

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1944 at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1944 to Oct 19 1944 and that I last saw h alive on Oct 19 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration 6 days

Due to: Hypertension and Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. Eversfield M. D.
Address 803 N. Fremont Date signed Oct 20

G21800

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21800 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2234 Penrose ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 2
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 Penrose ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna M. Milke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas K. G. Milke
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 22, 1883

8. AGE: Years 61 | Months 5 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Home wife
11. Industry or business

FATHER 12. Name William Brunner
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Wilhelmina Groth
15. Birthplace Baltimore

16 (a) Informant Thomas K. G. Milke
(b) Address 2234 Penrose ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn P.O.

18 (a) Funeral director Shadrick & Dole
(b) Address 1200 W. Lombard St.

19 (a) Oct 21 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-18 1944, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1944 to Oct 18 1944, and that I last saw h alive on 19

Immediate cause of death	Duration
Cerebral Hemorrhage	7 day
Due to Hypertension	
Due to	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas L. Carpenter M.D.
Address 2145 W Balto St Date signed 10/19/44

G21801

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G21801 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 209 N. Monroe
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 56 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County -
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 209 N. Monroe (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Mary C. Fennell

3 (b) If veteran, name war: no
3 (c) Social Security Account No. -

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 6 1870

8. AGE: Years 74 | Months 8 | Days 13 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Hat maker

11. Industry or business Mens Hat Shop

FATHER — 12. Name Henry Fennell
13. Birthplace Germany

MOTHER — 14. Maiden Name Mary Lutz
15. Birthplace Germany

16 (a) Informant Wm. H. Fennell (Bro.)
(b) Address 209 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 22 44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3201 Frederick Rd. Balto.

18 (a) Funeral director Jos. Jourdenais & Son
(b) Address 1927 Park Ave, City

19 (a) (b) Huntington Williams, M.D. Registrar

OCT 21 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1944, at 7.45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 3 1944, to Oct 19 1944, and that I last saw h[illegible] alive on Oct 18 1944.

Immediate cause of death: Broncho Pneumonia — Duration 10/17/44
Due to: Chr. Myocarditis — 1940
Due to:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul Brown
Address 1630 Clark St. Date signed 10/19/44

G21802

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

330

G21802

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1700 Park Ave 12
(c) Hospital or institution:
Miss Wheeler's Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos. or days) 2 yrs 10 mo.
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2801 St Paul St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? Life yrs.

3 (a) FULL NAME Sarah Elizabeth Burgess

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —None—

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 26 1865

8. AGE: Years 78 | Months 11 | Days 24 | If less than one day hr. min.

9. Birthplace Kent Co. Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business —

FATHER
12. Name Rachael Burgess
13. Birthplace Kent Co. Md.

MOTHER
14. Maiden Name Henrietta Tilden
15. Birthplace Kent Co. Md.

16 (a) Informant Miss Florence E. Burgess (Niece)
(b) Address 3017 N Calvert St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-44 (month) (day) (year)
(c) Cemetery or crematory Aldersgate
Location Kent Co Md.

18 (a) Funeral director Stewart Memorial
(b) Address 108 W Preston St.

19 (a) (Date rec'd by registrar) OCT 21 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20 1944, at 8 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944, to Oct 20 1944 and that I last saw h[illegible] alive on Oct 19 1944.

Immediate cause of death	Duration
Influenza	
and pulmonary oedema	week
Due to	
Due to	
Other Conditions Dementia	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

With Signature of Wm H Pearce M. D.
Address 205 Cherry Date signed Oct 21 /44

VS 2

G21803

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21803

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 14 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, City. (If outside city or town limits, write RURAL and give town)
(d) Street No. 617 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna G. Cain.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Edmond L. Cain

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1894

8. AGE: Years 50 | Months 9 | Days 4 | If less than one day hr. min.

9. Birthplace Pittsburg Pa. (Town, county, and state)

10. Usual Occupation House w/fe

11. Industry or business at home

FATHER
12. Name Thomas O'Neill.
13. Birthplace Penna.

MOTHER
14. Maiden Name unknown
15. Birthplace Penna.

16 (a) Informant Edmond L. Cain
(b) Address 617 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Dalton Ct.

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Av.

OCT 21 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1944, at 2:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1944 to 10/20 1944, and that I last saw h[illegible] alive on 10/20 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	
Due to Hypertension	? (No History)
Due to	
Other Conditions Dermoid cyst L[illegible] ovary (include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy: Cerebral Hemorrhage & Arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl N. Patterson M.D.
Address Mercy Hospital Date signed 10/20/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the...

VS 110

21804

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓ 50

Registered No. C21804

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2019 Sparks Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
Street No. 2019 Sparks Court
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pearl Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Monroe Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 17 1901

8. AGE: Years 42 | Months 10 | Days 1 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Kurowski
13. Birthplace Poland

MOTHER
14. Maiden Name Mary Kasperzak
15. Birthplace Poland

16 (a) Informant Monroe Jackson
(b) Address 2019 Sparks Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 23/44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem.
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 400 S. Chester Street

OCT 21 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION 2:20

20. DATE OF DEATH October 18, 1944, at P.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
(Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Breast, right.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollenweber M.D.
(Medical Examiner)
Date signed October 19, 1944.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the c

MARUSHOCK

G21805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓74a

G21805 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 Jeffery St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph M. Marushock
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife none
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-13-28

8. AGE: Years	Months	Days	If less than one day
16	5	7	hr. min.

9. Birthplace Pa (Town, county, and state)
10. Usual Occupation School
11. Industry or business none

FATHER
12. Name Michael Marushock
13. Birthplace Pa

MOTHER
14. Maiden Name Tonia Chadello
15. Birthplace Pa.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/44 (month) (day) (year)
(c) Cemetery or crematory St. Cyrils Methodist
Location Rockville, Penna.
18 (a) Funeral director John F Klemm Jr Earl Lees
(b) Address 715 Light St.
19 (a) [illegible] (Signature and address) Huntington Williams, M.D.

OCT 21 1944

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 20 1944 at 2:14 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1944 to Oct 20 1944 and that I last saw him alive on Oct 20 1944

Immediate cause of death	Duration
Respiratory Failure	
Due to Acute myllogenous	2 6 weeks
Due to Leukemia	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Abraham Geneen
Address Johns Hopkins Date signed 10-19-44 M. D.

G21805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 93D

Registered No. G21806

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 74 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 216 Ridgewood Road
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY WILSON WEBB

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife (Not known)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1870

8. AGE: Years 74 | Months 0 | Days 25 | If less than one day ~ hr. ~ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name William Webb (D)
13. Birthplace Maryland

MOTHER
14. Maiden Name Amanda Lee (D)
15. Birthplace Maryland

16 (a) Informant Mrs. Thomas Burrakes (daugh)
(b) Address 214 Geo. Thomas, Arlington, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director No. W. Meaks and Son
(b) Address 805 N. Calvert St.

19 (a) Date received by registrar OCT 21 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1944, at 8.05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from October 20 1944, to October 20 1944, and that I last saw him alive on October 20 1944.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Cerebro-vascular accident	
Due to Hypertensive heart disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Thompson Jr. M. D.
Address 332 E. University Pkwy Date signed 10/24/44

G21807 ✓ G21807

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1710 South Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1710 South Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSIAH SLICER BOWEN

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth Albertha Bowen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1882

8. AGE: Years	Months	Days	If less than one day
62	5	22	hr. min.

9. Birthplace Mt. Washington, Balto., Md.
(Town, county, and state)
10. Usual Occupation Medical Doctor
11. Industry or business Deputy State and County Health Officer

FATHER
12. Name Josiah Slicer Bowen
13. Birthplace Taylor Estate, Balto. Co., Md.

MOTHER
14. Maiden Name Rebecca Norma Mears
15. Birthplace Locustville, Accomac Co., Va.

16 (a) Informant Dr. Josiah S. Bowen
(b) Address 1710 South Rd., Mt. Wash., Balto.

17 (a) Burial (b) Date thereof 10/23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Filed by registrar) (b) Huntington Williams, Registrar

22104

Vs 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1944, at 9:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10 20 1944 to 10 20 1944; that I last saw him alive on 10 20 1944

Immediate cause of death Coronary Thrombosis — Duration 4 M 1 D

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature I. J. Nurkin M. D.

Address 1209 Baltimore Date signed Oct 20/ 1944

NURKIN

G21808 ✓ G21808

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Auchentoroly Terr.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Auchentoroly Terr.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY R. GRACE

3 (b) If veteran, name war --

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1870

8. AGE: Years 74 | Months - | Days 25 | If less than one day hr. min.

9. Birthplace Middletown, Va.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James W. Grace
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary A. Cailmon
15. Birthplace Ireland

16 (a) Informant Mrs. Elmer Hachman
(b) Address 3408 Auchentoroly Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart
Location Winchester, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) 10-22-1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20, 1944, at 1:00 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1935 to Oct 20 1944, and that I last saw deceased alive on Oct 20 1944

Immediate cause of death: Repeated Coronary Thromboses — Duration

Due to

Due to

Other Conditions: Generalized sclerosis — 9 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dewey P. Magruder M. D.

Address 33 26 Bradford Pl. Signed 10/24/44

G21809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G21809 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 40 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3008 Clifton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude S Davison

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Isaac

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business House Work

FATHER
12. Name Israel Raffel
13. Birthplace Russia

MOTHER
14. Maiden Name Rose Israelson
15. Birthplace Russia

16 (a) Informant Isaac Davison
(b) Address 3008 Clifton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct, 22, 1944 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) 10AA (Date rec'd by registrar) (b) Huntington Whitmore M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1944, at 3 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-6-44 1944 to 10-21 1944, and that I last saw her alive on 10-21 1944.

Immediate cause of death Respiratory Failure — Duration

Due to Cerebro-vascular accident - Probably

Due to Saba rachnoid Hemorrage & Hypertensive Cardio Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jerome F. Darkin M. D.
Address Sinai Hospital Date signed 10/21/44

G21810 ✓ G21810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Convalescent Home
(c) Hospital or institution: Cresbury & Ellamont Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 128 S. Calhoun St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louis Hills

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Miriam
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): 1889
8. AGE: Years ✓✓ Months Days If less than one day hr. min.
9. Birthplace: Germany (Town, county, and state)
10. Usual Occupation: Grocery Store
11. Industry or business

FATHER
12. Name Hellel
13. Birthplace Russia

MOTHER
14. Maiden Name Leah
15. Birthplace Russia

16 (a) Informant: Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-44 (month) (day) (year)
(c) Cemetery or crematory Pikesville
Location Pikesville Rd & Hampton Lane
18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St
19 (a) OCT 22 1944 (Date received by Registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-44 19 , at 6 A M

21. I certify that death occurred on the date above stated, that I attended deceased from July 17 1936, to Oct. 20 1944, and that I last saw h[illegible] alive on Oct. 20 1944

Immediate cause of death: Chronic myocardial degeneration — Duration: 1936
Due to: Cardiac hypertrophy — 1938
Due to: Arteriosclerosis — 1939
Due to: Coronary Sclerosis
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. A. Michelson M. D.
Address 2230 Eutaw St. Date signed 10/21/44

255041 G21811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G21811 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2529 Brookfield (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sara Goldman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, divorced: ~~married~~ widowed

6 (b) Name of husband or wife: 9-14-85-

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years: 58 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Harry Kramer
13. Birthplace: Russia

MOTHER
14. Maiden Name: Kate Silver
15. Birthplace: Russia

16 (a) Informant: records
(b) Address: JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-23-44 (month) (day) (year)
(c) Cemetery or crematory: Auz Chaim
Location: Washington Blvd

18 (a) Funeral director: Jack Levy Inc
(b) Address: 1437 E. Balto St. Huntington Williams, M.D.

19 (a) OCT 22 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/21 1944 to 10/21 1944, and that I last saw h[illegible] alive on 10/21 1944

Immediate cause of death: Cardiac Failure — Duration: 2wks
Due to: Myeloid Leukemia — ? 2 yrs
Due to:
Other Conditions: Diabetes Mellitus — 10 yrs
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Lauren V. Ackerman M. D.
Address: Johns Hopkins Date signed 10/21

G21812

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21812 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. (Do not use abbreviations.) Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2212 Baker St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2212 Baker St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Hankin

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: Harry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name David Jensen
13. Birthplace Russia

MOTHER
14. Maiden Name Dina
15. Birthplace Russia

16 (a) Informant Samuel J. Hankin
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location Pulaski Hy & Hamilton Ave

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) OCT 22 1944 (Date rec'd by registrar) (b) Huntington Wilson, Registrar, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21-44 19 at 1.15 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10-1944 to 10-21-1944 and that I last saw her alive on 10-20-1944.

Immediate cause of death	Duration
Bronchopneumonia	11 days
Cardiac Failure	11 days
Due to A-S. Ht. Dis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 10-21-44 at 1.15 A. M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Julius M. Wagbelstein M. D.
Address 6 E. Madison St Date signed 10-22-44

G2181B

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 54 B

G2181B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. Rutland Ave
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days) 35

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 117 N. Exeter St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Finkelstein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Nat Finkelstein

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day hr. min.

9. Birthplace Lith
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jacob Shevitz
13. Birthplace Lith

MOTHER
14. Maiden Name Mwedie –
15. Birthplace Lith

16 (a) Informant Jack Shevitz
(b) Address 1910 N. Dentaluan St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-22-44 (month) (day) (year)
(c) Cemetery or crematory Rose dale
Location

18 (a) Funeral director Jack Lewis Inc
(b) Address 143 E. Balti St

19 (a) [illegible] (Registrar) Huntington Williams M.D. Registrar

OCT 22 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-44 19 , at 12 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19- 1944, to 10-20, 1944, and that I last saw h[illegible] alive on 10-19 1944.

Immediate cause of death acute
pulmonary edema

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address Sinai Hospital Date signed 10/21/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

621814

[redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. 621814

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3503 Oakmont Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ?
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3503 Oakmont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George W. Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-01-2304

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Marie A. Santry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 6 1881

8. AGE: Years	Months	Days	If less than one day
63		13	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Electrician
11. Industry or business

FATHER
12. Name Lewis H. Robinson
13. Birthplace Lancaster Va

MOTHER
14. Maiden Name Sarah R. Morris
15. Birthplace Balto Md

16 (a) Informant Marie A Robinson
(b) Address 3503 Oakmont Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Old Frederick Road

18 (a) Funeral director John J. Fahey & Sons
(b) Address 1318 Light St

OCT 22 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 19 1944 at 12 Noon

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 1 1943 to Oct 19 1944 and that I last saw [redacted] alive on Oct 16 1944

Immediate cause of death	Duration
Carcinoma Left Lung	about 1 yr
Due to ?	
Due to ?	
Other Conditions General Carcinomatosis. (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [redacted] M. D.
Address [redacted] Date signed Oct 20 1944

G21815

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G21815 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp. 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 N. Augusta Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida V. Shockley

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Noah D.C. Shockley | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 19th 1869

8. AGE: Years 75 | Months 9 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Noah Shockley Baptism Not
13. Birthplace ? Md.

MOTHER 14. Maiden Name Hattie Rusard
15. Birthplace Md.

16 (a) Informant Bertha Stripling
(b) Address c/o Albert G. Bell E. Shaw St.

17 (a) Burial (b) Date thereof 10 (month) 23 (day) 44 (year)
(Burial, cremation, or removal)

(c) Cemetery or crematory Old School Baptist
Location Green Hill, Md.

18 (a) Funeral director Geo. Kiba & Son
(b) Address 2503 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 22 1944 Huntington Williams, M.D

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1944, at 7:50 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1944 to 10/21 1944, and that I last saw her alive on 10/21 1944

Immediate cause of death: Bronchopneumonia — Duration

Due to

Due to

Other Conditions Hypertension C-V disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers M. D.
Address Franklin Sq. Hosp. Date signed 10/22/44

G21816

332724

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 552

G21816 Registered No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Fla. (b) County
(c) City or town Kissimmee (If outside city or town limits, write RURAL and give town)
(d) Street No. 304 Hughey Street (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Buckels

3 (b) If veteran, name war: World I
3 (c) Social Security Account No. -
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Gene J. Buckels
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10-7-92
8. AGE: Years 52 Months - Days 14 If less than one day hr. min.
9. Birthplace Fla. (Town, county, and state)
10. Usual Occupation Utilities
11. Industry or business

FATHER
12. Name Calvin Buckels
13. Birthplace Fla.

MOTHER
14. Maiden Name Henrietta Bronson
15. Birthplace Fla.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL
17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 22-1944 (month) (day) (year)
(c) Cemetery or crematory Rose Hill
Location Kissimmee, Florida
18 (a) Funeral director Burgess Funeral Home
(b) Address 3621 Falls Road
(c) (Date received by Registrar) (b) Huntington Williams, M.E.

OCT 22 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 - 1944, at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21-1944 to 10-21 1944, and that I last saw him alive on 10-21-1944.

Immediate cause of death	Duration
Cardiac Failure	8 hrs
Pleural Effusion	
Due to Lymphosarcoma	6 mo
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Calvin Buckels
Address Johns Hopkins Date signed 10/24/44 M. D.

G21817

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 148a

G21817 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Druid Hill Ave (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Frances Williams Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-20-9670

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Widowed.

6 (b) Name of husband or wife Henry Jackson
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 1906

8. AGE: Years	Months	Days	If less than one day
38	10 11	12	hr. min.

9. Birthplace Manning, S. C. (Town, county, and state)
10. Usual Occupation Maid.
11. Industry or business Store

FATHER
12. Name James Williams
13. Birthplace Manning, S. C.

MOTHER
14. Maiden Name Henrietta Nead
15. Birthplace Manning, S. C.

16 (a) Informant Doris Brown (niece)
(b) Address 2405 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 22, 1944 (month) (day) (year)
(c) Cemetery or crematory —
Location [illegible] Manning, S.C.

18 (a) Funeral director Mrs. Lee H. Hayland
(b) Address 1691 Druid Hill Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

OCT 22 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1944, at 3 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1, 1944, to Oct 20, 1944 and that I last saw her alive on Oct 20, 1944

Immediate cause of death Carcinoma of cervix — Duration 4 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature N. Louise Young, M.D.
Address 1100 Druid Hill Ave Date signed 10/21/44

G21818 BALTIMORE CITY HEALTH DEPARTMENT G21818

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 422 Normandy
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 422 Normandy Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Agnes Mary Mallonee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 1856

8. AGE: Years 86 | Months - | Days 28 | Hours Less than one day | min.

9. Birthplace Balt Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Saptmyer
15. Birthplace Md

16 (a) Informant Julian Richardson
(b) Address Toronto Canada

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Balto Md

18 (a) Funeral director Geo A Fahey
(b) Address Fulton & Fayette

10-23 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1944, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 19 1944 to Oct 21 1944 and that I last saw h[illegible] alive on Oct 19 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration: Few hours

Due to (or as a consequence of): Hypertension

Due to (or as a consequence of): Senility

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter Thomson M. D.
Address 422 Normandy Ave Date signed 10-23-44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G21819

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G21819
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 6 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk P.O.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Trappe & Grange Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Joseph Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-21-44-1 day

8. AGE: Years | Months | Days | If less than one day: 6 hr. 10 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Thomas Bayard Williams Jr.
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Genevieve Louise Clarke
15. Birthplace Baltimore Md.

16 (a) Informant Mr. T. Bayard Williams
(b) Address Trappe & Grange Roads

17 (a) Burial (b) Date thereof 10/23/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Greenstone
(b) Address 805 N. Calvert St.

19 (a) OCT 23 1944 (b) Hunting for Williams Brothers
(Date received by registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21 1944 at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1944 to 10/21 1944, and that I last saw him alive on 10/21 1944.

	Duration
Immediate cause of death: Congenital atelectasis	
Due to: Pneumonitis	6 mos.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature Raymond Long M. D.
Address 5 E. Lanvale St. Date signed 10/24/44

G21820

BALTIMORE CITY HEALTH DEPARTMENT ✓ G21820

CERTIFICATE OF DEATH 117a

Registered No.

G21820
Y&L-90248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 49 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 26
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6524 Cleveland Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lafayette Fitzpatrick ✓

3 (b) If veteran, name war I | 3 (c) Social Security Account No. ?

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 1896

8. AGE: Years 48 | Months 2 | Days 28 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation
11. Industry or business Eastern Aircraft

FATHER
12. Name Amos Fitzpatrick
13. Birthplace Ky.

MOTHER
14. Maiden Name Sarah Aldridge
15. Birthplace Ky.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Removal (b) Date thereof 10/23/44
(burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Madonna
Location Madonna Md.

18 (a) Funeral director Fallon Funeral Home
(b) Address 127 S. Paca St.

19 (a) (Date rec'd by registrar) (b) Huntingdon Pa.

OCT 23 1944
VS Form

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 20, 1944, at 1:15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1944 to 10-20 1944, and that I last saw him alive on 10-19 1944

Immediate cause of death: Pneumonia — Duration

Due to: Post Operative Perforated Gastric Ulcer C Peritonitis — 4 days

Due to:

Other Conditions: Acute Alcoholism & Delirium Tremens
(Include pregnancy within 3 months of death)

Date of operation 10-16-44

Major findings of operation: Perforated Gastric Ulcer & Peritonitis

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. Butler M. D.
Address East City Hosp Date signed 10-22-44

MAYS

G21821

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

G21821 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5826 Clark Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-13
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yr 10 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Hiel (If outside city or town limits, write "rural" and give town)
(d) Street No. 5826 Clark Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William Nicholas Mayo

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower.

6 (b) Name of husband or wife: Mary Frances Mayo

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 28, 1855

8. AGE: Years 89 | Months 7 | Days 27 | If less than one day ____ hr. ____ min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Farmer (Retired)

11. Industry or business

FATHER
12. Name Abraham Mayo
13. Birthplace Md.

MOTHER
14. Maiden Name Lydia Hershberger
15. Birthplace Md.

16 (a) Informant Pearl Mayo (Daughter)
(b) Address 5826 Clark Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-44 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Baltimore Md.

18 (a) Funeral director Walter R. McDaniel
(b) Address 4114 Edmondson Ave.

19 (a) (b) Interment for Williamsport Md.

Oct 23 1944

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1944 at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1, 1944, to Oct. 1944 and that I last saw him alive on Oct 20 1944.

Immediate cause of death: Congestive Heart Failure. — Duration:
Due to: Arteriosclerotic Cardio-Vascular Disease. — Duration:
Due to: — Duration:
Other Conditions: — Duration:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edw. L. Hersperger M.D.

Address 4077 Falls Rd. Date signed 10/24/44

G21822

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D ✓

G21822 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 13 E. Eager street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ---
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 13 E. Eager street (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HELEN MARIA HAYWARD

3 (b) If veteran, name war ----
3 (c) Social Security Account No. ----

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband or wife Thomas B. Hayward
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 22, 1845

8. AGE: Years	Months	Days	If less than one day
99	6	27	hr. min.

9. Birthplace Cecil Co., Maryland (Town, county, and state)
10. Usual Occupation At home
11. Industry or business

FATHER
12. Name Bennett Bussey
13. Birthplace Maryland

MOTHER
14. Maiden Name Ann Maria Black
15. Birthplace Cecil Co. Md.

16 (a) Informant Dr. Eugene H. Hayward
(b) Address 13 E. Eager street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory St. Mary's
Location Govans

18 (a) Funeral director Chas. J. Evans Son
(b) Address 118 N. Mt. Royal Ave.

19 (a) OCT 23 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 1921, to Oct 19 1944, and that I last saw h.w alive on Oct 18 1944.

Immediate cause of death: Chron. myocarditis — Duration 20 yrs
Due to: Arteriosclerosis — 10 yrs
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature A. M. Barone M. D.
Address 2510 Taylor Ave. Date signed 10/20/44

G21823

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G21823 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address East 33rd St.
(c) Hospital or institution: The Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Lake Drive (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Beatrice Ulman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Jewish | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Robert Lee Ulman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 21, 1884

8. AGE: Years 60 | Months - | Days - | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Heyman Harris
13. Birthplace Germany

MOTHER 14. Maiden Name Rena Buckler
15. Birthplace Germany

16 (a) Informant Mrs Harry Rubenstein
(b) Address 709 Lake Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore & Conkling Sts

18 (a) Funeral director Jacob Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) OCT 23 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21 1944, at 10:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 13, 1944, to October 21, 1944, and that I last saw her alive on October 21, 1944

Immediate cause of death: Cause unknown (Coronary Thrombosis ?) Cardio-respiratory — Duration: Instantaneous

Due to

Due to

Other Conditions: Diarrhea of unknown etiology
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Stephen J VanLill Jr M. D.
Address Union Memorial Hosp. Date signed 10-21-44

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21824 — 927 — G21824

CERTIFICATE OF DEATH

PLACE OF DEATH

CITY OF BALTIMORE: (No. 1521 Homestead St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME William Franklin Tull

If U. S. Veteran specify WAR

(a) Residence: No. 1521 Homestead St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Mary U. Tull

6. DATE OF BIRTH (month, day, year) Nov 23rd 1884

7. AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
59	10	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Watchman

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Okahns Garage

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto Md

FATHER

13. NAME William L. Tull

14. BIRTHPLACE (city or town) (State or country) Pocomoke Md.

MOTHER

15. MAIDEN NAME Lena Keim

16. BIRTHPLACE (city or town) (State or country) Balto Md.

17. INFORMANT Mary B. Tull
(Address) 1521 Homestead St.

18. BURIAL, CREMATION, OR REMOVAL
Balto Place Burial Date 10/24 19 44

19. UNDERTAKER William Cook Inc
(Address) 1217 St. Paul St

20. FILED ... 19... Huntington Williams Registrar.

OCT 23 1944

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 21st, 1944

22. I HEREBY CERTIFY, That I attended deceased from May 4, 19KK to Oct 21, 19KK

I last saw h... alive on Oct 19, 19KK Death is said to have occurred on the date stated above, at 5:30 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Dilatation	1 day

Other contributory causes of importance:

Chr Valvular Heart Dis	4 yr.
Chr Bronchial asthma	

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?

... If so, specify ...

(Signed) C N Meyer M. D.

(Address) 15 W Eager

Information should be carefully supplied. All items must be answered. If it is impossible to obtain exact statement of facts, approximate statement may be given. Be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G21825 V G21825

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1635 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1635 N. Gay St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MANNIE MAHER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/6/1888

8. AGE: Years	Months	Days	If less than one day
56	6	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John Jenkins
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Carrie Baker
15. Birthplace Balto. Md.

16 (a) Informant August Mafer
(b) Address 1635 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md

18 (a) Funeral director Wilfred Lockwood
(b) Address 1217 St. Paul St.

19 (a) (Date filed by registrar) (b) Registrar

OCT 25 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 19 44 at 9:00 A.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.

Date signed 10-22-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21826

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G21826 Registered No.

PLEASE WRITE PLAINLY, with UNFADING INK. Entry must be complete and correct as to information above the line. Use additional sheet of this size if necessary. Answer all questions so far as known. Give usual name of occupation, even if retired. Where there is a doubt as to the correct age, the exact date of birth should be given. If the deceased was a married woman, the name should be that of her husband. If any of the items are unknown, the word unknown should be written. Where the cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Sinai Baltimore General
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 N. Calvert St (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME John Gowland

3 (b) If veteran, name war: W

3 (c) Social Security Account No.: None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret T.

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 7th 1887

8. AGE: Years	Months	Days	If less than one day
57	2	13	..... hr. ..... min.

9. Birthplace York England (Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business Fairfield - Bethlehem

FATHER
12. Name James Gowland
13. Birthplace England

MOTHER
14. Maiden Name Jane Humphreys
15. Birthplace England

16 (a) Informant Margaret T. Gowland
(b) Address 1613 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto Md.

18 (a) Funeral director William Cook Inc
(b) Address 127 St Paul St

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20 1944, at 2:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to Angina pectoris

Other Conditions.....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury..... at..... M.
(b) Where did injury occur?.....
(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....
(d) Means of injury.....

23. Signature Robert Lee Slater M.D. Medical Examiner.
Date signed October 20, 1944

G21827 BALTIMORE CITY HEALTH DEPARTMENT G21827
Registered No.

CERTIFICATE OF DEATH 92a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 weeks

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Philadelphia (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME R. LAWSON DRURY

3 (b) If veteran, name war —
3 (c) Social Security Account No. 212-18-6442

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/25/1875

8. AGE: Years	Months	Days	If less than one day
69	7	25	— hr. — min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business B&O R.R.

FATHER
12. Name Charles Drury
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Cora DeCamp
15. Birthplace Washington D.C.

16 (a) Informant Sadie B. Wolf
(b) Address 1559 Abbottston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (Date rec'd by registrar) (Huntington for Williams, M.D.) Registrar

OCT 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20 1944, at 2:09 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7:30 PM 10-19-1944 to 2 AM 10-20-1944, and that I last saw him alive on 10-20-1944.

Immediate cause of death Cardiac dilatation

	Duration
Due to Aortic insufficiency, Mitral Stenosis	7
Due to Rheumatic Heart Disease	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. V. Palmer M. D.
Address University Hospital Date signed 10/20/44

G21828

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. G2[illegible]3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or location 33rd & Calvert
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 509 Rosehill Terrace (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) **FULL NAME** Charles E. Landman

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 10, 1863

8. AGE: Years 81 | Months 6 | Days 11[illegible] | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation — Retired

11. Industry or business —

FATHER
12. Name Henry Landman
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace ?

16 (a) Informant Mrs John W.F. Murphy
(b) Address 509 Rosehill Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/44 (month) (day) (year)
(c) Cemetery or crematory Balto
Location Balto. Md.

18 (a) Funeral director William Cox Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 22 (Date rec'd by registrar) (b) Funeral for William M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1944 at 3[illegible] PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1944 to Oct. 21 1944, and that I last saw him alive on Oct. 21 1944.

Immediate cause of death Broncho pneumonia — Duration

Due to

Due to

Other Conditions [illegible]

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature John D. Morris M. D.
Address 1 W A Date signed 10-21-44

G21829

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21829

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 413 E Lanvale st
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN H SILMAN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/23/1889

8. AGE: Years 54 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Machinist

11. Industry or business Liberty Motors

FATHER
12. Name George M. Silman
13. Birthplace Unknown

MOTHER
14. Maiden Name Betty Silman
15. Birthplace Unknown

16 (a) Informant Hazel M. Silman
(b) Address 405 E. Lanvale St

17 (a) Removal (b) Date thereof 10-23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bridgewater, Va.
Location

18 (a) Funeral director Wilkerson Lodge Inc.
(b) Address 1217 St. Paul St.

19 (a) OCT 23 1944 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1944, at 1 30 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollenweber M.D.
Medical Examiner.
Date signed 10-23-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

OCT 23 1944

G21830

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 121a

G21830
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 711 Druid Hill ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 711 Druid Hill ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	colored	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1848

8. AGE: Years	Months	Days	If less than one day
96			hr. min.

9. Birthplace Eastern Shore, Md.
(Town, county, and state)
10. Usual Occupation Shade Worker.
11. Industry or business

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden Name
15. Birthplace Unknown

16 (a) Informant Lillian Stewart
(b) Address 711 Druid Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23, 1944 (month) (day) (year)
(c) Cemetery or crematory Ft. Calvary
Location

18 (a) Funeral director A. Wakefield
(b) Address 911 Druid Hill Ave.

19 (a) 23 Oct 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 15, 1944, at M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/11 1944 to 10/15 1944, and that I last saw h alive on 10/11 1944.

Immediate cause of death	Duration
Hypertension Cardiovascular Renal	1 year
Due to Cerebral Hemorrhage	
Due to Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Jackson M. D.
Address 1400 Madison Ave Date signed 10/24/44

21831

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95 B

Registered No. G21831

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution: Mercy Hospital 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Born here

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto. City.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 667 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Haines

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1904

8. AGE: Years	Months	Days	If less than one day
40	3	13	hr. min.

9. Birthplace Baltimore, MD.
(Town, county, and state)
10. Usual Occupation Mechanic - Unemployed.
11. Industry or business

FATHER
12. Name Richard Haines
13. Birthplace Baltimore

MOTHER
14. Maiden Name Garnie Boyer
15. Birthplace Maryland.

16 (a) Informant Stanley Haines
(b) Address Lutherville, MD.

17 (a) Removal (b) Date thereof Oct. 24, 1944
(Burial, cremation, or removal)
(c) Cemetery or crematory [redacted] Co.
Location [redacted] MD

18 (a) Funeral director [redacted] A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 23 1944 (b) Huntington Williams MD
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14 1944 at 7:24 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Oct 14 1944 and that I last saw him alive on Oct 13 1944.

Immediate cause of death	Duration
Cardio-respiratory failure.	
Due to Pneumonia, Hypostatic	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward L. Rayford M.D.
Address Mercy Hospital Date signed Oct 23 1944

G21832

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 93

Registered No. G21832

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 682 Josephine St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, City
(If outside city or town limits, write RURAL and name town)
(d) Street No. 682 Josephine Street
(If rural give location)
(e) Citizen of foreign country? no. (Yes or No)
If yes, name country

3 (a) FULL NAME Corina Henson (Bibbins)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: colored | 6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Ollie Evans

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1904

8. AGE: Years 40 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation Domestic work.

11. Industry or business

FATHER
12. Name Emanuel Henson
13. Birthplace Md.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Emmett Smallwood
(b) Address 682 Josephine Street.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) 10-23-44 (Date rec'd by registrar) (b) Hunting for Williamsburg Va.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1944, at 10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1944 to Oct 24 1944
and that I last saw h[illegible] alive on Oct 24 1944

Immediate cause of death	Duration
Coronary Thrombosis	2 wks
Due to Hypertension	
Due to Carcinoma of Pancreas	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Rechtmyer M.D.
Address 426 N. Johnson St. Date signed 10/25/44

VS 150

G21833

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1218

✓ G21833 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 634 Hanover st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-2
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 634 Hanover st (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Cora Kiah

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	C.	Married

6 (b) Name of husband or wife Cora Kiah
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
59			hr. min.

9. Birthplace Cambridge Md (Town, county, and state)
10. Usual Occupation
11. Industry or business Laborer

FATHER
12. Name Charles Kiah
13. Birthplace Cambridge Md

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Cora Kiah
(b) Address 634 Hanover st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Single grave

18 (a) Funeral director Jr Jones
(b) Address 111 S. Gilmor st

19 (a) [illegible] (b) [illegible]
Registered

OCT 23 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/16 1944, at [illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/12 1944, to 10/16 1944, and that I last saw him alive on 10/17 1944.

Immediate cause of death
Chr. Nephritis & Chr. Ht.
Due to Uremia
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ben Rhetta
Address 54 W Mt Rd Date signed 10/20/44

G21834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21834 ✓ Registered No.

TO #86144

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 mos. 24 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 17 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1620 Mountmor Court (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME John Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1921

8. AGE: Years	Months	Days	If less than one day
23	-4-	-7-	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name James Smith (d)
13. Birthplace South Carolina

MOTHER
14. Maiden Name Georgiana Foster (d)
15. Birthplace South Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/23/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location A.A.County, Md

18 (a) Funeral director Charles G.Cooper Ave
(b) Address 512 N.Carrollton Ave

19 (a) OCT 23 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 18, 1944, at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 24, 1944, to Oct. 18, 1944, and that I last saw him alive on Oct. 17, 1944.

Immediate cause of death	Duration
Heart failure	
Due to Miliary Tuberculosis	2 mo
Due to	over
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dalton M.D.
Address Balto City Hosp Date signed 10/19/44

G21835 ✓ G21835

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. 16 3

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1026 N. Gilmor St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 20yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1026 N. Gilmore St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Hand

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	M

6 (b) Name of husband or wife Marian Hand

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20- 1906

8. AGE: Years	Months	Days	If less than one day
38 40	11	25	hr. min.

9. Birthplace Bergan. N. C (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Hand
13. Birthplace N. C

MOTHER
14. Maiden Name Louise Williams
15. Birthplace N. C

16 (a) Informant Marian Hand
(b) Address 1026 N. Gilmor St

17 (a) Burial (b) Date thereof Oct 23-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Wilmington N C

18 (a) Funeral director Sam W. Chase Hse
(b) Address 638 N. Gilmor St

19 (a) OCT 23 1944 (b) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/20 1944, at 9.00 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNelley M.D. Medical Examiner.
Date signed 10/24/44

VS 151

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

20836

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G21836
Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1637 E. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3-1
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1637 E. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Frances Goff

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or ~~wife~~ Matthew Goff
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15, 1890

8. AGE: Years	Months	Days	If less than one day
54 yrs.	4	5	hr. min.

9. Birthplace Providence, R. I.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Blake
13. Birthplace unknown

MOTHER
14. Maiden Name Nellie Cronin
15. Birthplace Providence, R. I.

16 (a) Informant Husband
(b) Address 1637 E. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-23-44 (month) (day) (year)
(c) Cemetery or ~~Crematory~~ Glen Haven Mem. Park
Location Glen Burnie, Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

OCT 23 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-20 1944 at 6A M

21. I certify that death occurred on the date above stated; that I attended deceased from March 1944 to Oct 20 1944, and that I last saw h[illegible] alive on Oct 19 1944.

Immediate cause of death: Acute Cardio-Respiratory Failure
Due to Bronchopneumonia
Due to Diabetes Mellitus
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

Duration: acute / 6 mo. / yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 2001 E. Pratt St. Date signed 10/23/44 M. D.

G21837 Greutman BALTIMORE CITY HEALTH DEPARTMENT ✓ G21837
Registered No.

CERTIFICATE OF DEATH 108

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hubert & Saratoga Sts.
(c) Hospital or institution: Mercy Hosp. 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County Balto 5
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Guilford Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Madeline Greutman ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife John D. Greutman
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 11/12/1892

8. AGE: Years	Months	Days	If less than one day
51	11	26	____hr. ____min.

9. Birthplace Boston, Mass.
(Town, county, and state)
10. Usual Occupation Housewife.
11. Industry or business

FATHER
12. Name Herbert Dow.
13. Birthplace England

MOTHER
14. Maiden Name Greenwood.
15. Birthplace Scotland

16 (a) Informant Husband.
(b) Address 1608 Guilford Ave.

17 (a) Burial (b) Date thereof 10/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mayland Park,
Location Rosedale Md.

18 (a) Funeral director J. Melville Jenkins
(b) Address 2713 Kirk Ave

19 OCT 23 1944 Christine Williams M.D.
(Date rec'd by registrar) Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 19 44, at 2400 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 19 44 to Oct 24 19 44, and that I last saw h[illegible] alive on Oct 20 19 44.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	over
Due to	
Other Conditions	
(Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edwin F. Bierfeldt M.D.
Address Mercy Hospital Date signed 10/24/44

G21838 ✓ G21838

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 97

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1335 W. Lombard St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1335 W. Lombard St (If rural give location)
(e) Citizen of foreign country? = (Yes or No)
If yes, name country

3 (a) FULL NAME Valentine Hartman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Annie H. Hartman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27-1850

8. AGE: Years 94 | Months 4 | Days 23 75 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Ret. Carpenter

11. Industry or business B & O Railroad

FATHER 12. Name Christopher Hartman
13. Birthplace Unknown

MOTHER 14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs Lillie Hartman
(b) Address 335 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel
Location Frederick Co. Md

18 (a) Funeral director Geo. L. Beyer Jr
(b) Address 1517 Hollins St

OCT 23 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21st 1944 at 12:01 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1944 to Oct 21 1944 and that I last saw him alive on Oct 21 1944

Immediate cause of death Hypostatic Pneumonia — Duration 10 hr/c/w.u.

Due to Generalized Arteriosclerosis — ?

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Earl P. Ross M. D.

Address 336 W Lombard St Date signed 10/27/44

G21839

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170 c

G21839 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution Union Memorial Hosp. 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Westfield ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F. Geoghegan

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-8872

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Verdie B. Geoghegan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1874

8. AGE: Years	Months	Days	If less than one day
69	11	17	hr. min.

9. Birthplace Dorchester Co, Maryland
(Town, county, and state)

10. Usual Occupation Cabinet Maker

11. Industry or business

FATHER 12. Name Moses Geoghegan
13. Birthplace Md.

MOTHER 14. Maiden Name Ellmery Wallace
15. Birthplace Md.

16 (a) Informant Verdie B. Geoghegan
(b) Address 3213 Westfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2924 Orleans Street

19 (a) (Date rec'd by registrar) OCT 23 1944 (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21- 1944, at 7 25 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Cervical Vertebrae
Fractured skull.

Due to

Other Conditions Fractured ribs - lacerations, etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-21- at 6.25 A M 27/7
(b) Where did injury occur? 6400 block Harford Road
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Mendelsohn M.D.
Medical Examiner.
Date signed 10-21-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entries must be complete and correct as to facts of death, and the causes of death clearly and legibly. Answer every question; if none or unknown, write "None" or "Unknown". Where a question does not apply, write "N.A." The space for "Length of stay" should be filled in for all deaths occurring in hospitals or institutions. Do not abbreviate. Do not use ditto marks. Be sure that the cause of death is stated in terms of disease and not in terms of mode of dying. Such terms as heart failure, asthenia, anemia, uremia, convulsions, etc., are not sufficient. The cause of death must be certified to the best of the knowledge and belief of the person who signs the certificate. Physicians: please write the correct age is especially important.

C21810

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. C21810

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 Baltimore, Maryland
(c) Hospital or institution:
Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3411 Towne St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE E. THORNE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Henry A Thorne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 28 1862

8. AGE: Years 82 | Months 4 | Days 27 | If less than one day hr. min. 24

9. Birthplace Baltimore, Md.
(Town, county, and State)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Wm. H. Boneman
13. Birthplace Germany

MOTHER
14. Maiden Name Mary H.
15. Birthplace Germany

16 (a) Informant Harry L. Baffin
(b) Address 3411 Towne Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Herring Sons
(b) Address 2024 Orleans Street

OCT 23 1944 (Date rec'd by registrar)
(b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1944, at 7 20 pm M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wollenweber M.D.
Medical Examiner.
Date signed 10-24-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21841

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47a

G21841 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2033 N. Calvert St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles W. Wisner Jr

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-27-94

8. AGE: Years 69 | Months 1 | Days 25 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Lawyer

11. Industry or business

FATHER
12. Name Charles W. Wisner
13. Birthplace Md

MOTHER
14. Maiden Name Mary Ellen Jackson
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24 44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville Md
18 (a) Funeral director Wm. Ottinger Miller Home
(b) Address 1900 Eutaw Place
19 (a) OCT 23 1944 (Date received by Registrar) Hunting for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1944 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 21 1944 to Oct 21 1944, and that I last saw h alive on Oct 21 19 44

Immediate cause of death	Duration
Respiratory Obstruction	
Due to Carcinoma Bronchus Cyst Neoplasm	2 mo
Due to	
Other Conditions Benign Prostatic Hypertrophy	

(Include pregnancy within 3 months of death)

Date of operation March 1944

Major findings of operation: Carcinoma of Bronchus - Cyst Neoplasm

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. M. Wahl M.D.
Address Jn 44 Date signed 10/24/44

G21842

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21842 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2130 Wilkens Avenue
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2130 Wilkens Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. Patten

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary L. Patten
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 18, 1857

8. AGE: Years	Months	Days	If less than one day
87	1	4	hr. min.

9. Birthplace N.Y. City (town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Ruth A.L. Patten
(b) Address 2130 Wilkens Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25 '44 (month) (day) (year)
(c) Cemetery or crematory London Park Cemetery
Location 3801 Frederick Avenue

18 (a) Funeral director John O. Mitchell & Son
(b) Address 1900 Eutaw Pl.

19 (a) OCT 23 1944 (Date rec'd by registrar) (b) Huntington Williams Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1944 at M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Cerebral embolism
Cardiovascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner)
Date signed Oct. 23 1944

Correct age is especially important. Typewriter, pencil or pen may be used, but ink must be indelible.

G21843

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G21843 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument + Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Brooke Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie K. Attenheimer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband Emanuel E. Attenheimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1881

8. AGE: Years	Months	Days	If less than one day
63	3	28	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER: 12. Name Meyer Katzenberg
13. Birthplace Balto. Md.

MOTHER: 14. Maiden Name Hanna V. Berney
15. Birthplace Balto. Md.

16 (a) Informant Mrs. Edwin Attenheimer
(b) Address 914 Brooke Lane

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/44 (month) (day) (year)
(c) Cemetery or crematory Ahb Shalom
Location Balto. Md.

18 (a) Funeral director Harris Levine & Son
(b) Address 1902 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1944, at 12 noon

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1944 to Oct 22 1944, and that I last saw her alive on Oct 22 1944

Immediate cause of death Cardio-respiratory failure.

Duration

Due to Intracranial hemorrhage.

Due to Arteria-sclerosis

Other Conditions Rheumatic Heart Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Intracranial hemorrhage

not proved yet by post mortem

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Leonard Lucher M.D.
Address Sinai Hospital Date signed 10/23/44

G21844

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 936

G21844

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2268 Brookfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) About 80 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2268 Brookfield Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME BETTIE LAUPHEIMER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Robert Laupheimer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1858

8. AGE: Years 85 | Months 11 | Days 29 | If less than one day hr. min.

9. Birthplace New York. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Abraham Friedemann,
13. Birthplace Unknown.

MOTHER
14. Maiden Name ? Lapinsky,
15. Birthplace Unknown.

16 (a) Informant Miss. Bessie Laupheimer,
(b) Address 2268 Brookfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/44. (month) (day) (year)
(c) Cemetery Hebrew Friendship
Location Balto. Md.

18 (a) Funeral director David Sonnheim & Son
(b) Address 1902 Eutaw Place.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 10 OCT 23 1944 Hunter for Williams, MD

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 22, Md. 1944, at 12.40 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1930. to Oct. 22 1944, and that I last saw h alive on Oct 21 1944.

	Duration
Immediate cause of death: myocardial weakness.	8 days
Due to: senile Bronchitis.	14 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Sue Lobstein M. D.
Address 1720 Eutaw Place. Date signed 10/23/44

335273 G21845

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21845 1330a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Cecil
(c) City or town Perryville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joyce Harrington

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex female

5. Color or race white

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife James J Harrington

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1- 1911

8. AGE: Years 33 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace Minn. (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name J. T. Frost
13. Birthplace N. Y.

MOTHER
14. Maiden Name Ina Nutting
15. Birthplace Minn.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal or Burial (Burial, cremation, or removal) Date thereof Oct. 23-1944 (month) (day) (year)
(c) Cemetery or crematory Forest Home
Location Milwaukee, Wisconsin

18 (a) Funeral director Durgee Funeral Home
(b) Address 3631 Falls Road

19 (a) OCT 23 1944 (Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1944, at 2.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1944 to Oct 22 1944 and that I last saw her alive on Oct. 22 1944

Immediate cause of death: UREMIA- uremic pericarditis; Cardiac Failure — Duration: 3 days

Due to: Chronic Pyelonephritis — 8-20 yrs

Due to:

Other Conditions: Anemia- Thrombopenia Hypocalcemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Anatomical Diag. 10/23/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [signature] M.D.

Address Johns Hopkins Date signed 10/22

G21816

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21816

YA-61446 G21816 / 13B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr., 5 mos., 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 4141 Fiverman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. Dignan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Wid.

6 (b) Name of husband or wife John (deceased)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1904

8. AGE: Years	Months	Days	If less than one day
40	—	5	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation
11. Industry or business

MOTHER / FATHER
12. Name George Gruer
13. Birthplace Maryland
14. Maiden Name Mary Sondergeld
15. Birthplace Maryland

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location

18 (a) Funeral director [illegible]
(b) Address [illegible]

19 (a) OCT 23 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 21, 1944, at 3:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 20 1944 and that I last saw h[illegible] alive on Oct 20 1944

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary Tuberculosis	6 mos.
Due to	
Other Conditions Parkinson's Disease (Include pregnancy within 3 months of death)	10 years

Date of operation
Major findings of operation:
of autopsy: confirmatory

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 10/24/44

G21847 G21847

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 740

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Caroline ST
(c) Hospital or institution: St. Josephs Hospital 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5928 Sefton ave 14
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Elizabeth Maas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	married

6 (b) Name of husband or wife Eugene A. Maas
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7-1892

8. AGE: Years	Months	Days	If less than one day
52	5	15	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Hse wife at home

11. Industry or business

FATHER
12. Name Frank Scheurich
13. Birthplace Germany

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Eugene A. Maas
(b) Address 5928 Sefton Ave

17 (a) Burial (b) Date thereof 10-25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Leonard D. Ruck
(b) Address 5305 Harford Road

19 (a) OCT 23 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1944 at 1 EA M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1944, to 10-22 1944, and that I last saw her alive on 10-22 1944

Immediate cause of death Aleukemic Leukemia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Fluid in Rt. Chest

of autopsy: Large spleen

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St Josephs Hosp Date signed 10-22-44

G21818 BALTIMORE CITY HEALTH DEPARTMENT X G21818 Registered No.

CERTIFICATE OF DEATH 157 M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Carrollton
(c) Hospital or institution: St. Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Towson (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Yakona Rd (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Harry Wilson Chaney Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, ~~married, widowed,~~ or ~~divorced~~.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-15-44

8. AGE: Years | Months | Days 2 | If less than one day hr. min.

9. Birthplace St. Joseph's Hosp. Balto. Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER 12. Name Unk

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant Hospital Records

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-21-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Baltimore

18 (a) Funeral director Leonard J. Ryan

(b) Address 5305 Harford Road

19 (a) (b) Registrar

OCT 23 1944 VS-150

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-15 1944 at 12 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15 1944 to 10-15 1944, and that I last saw him alive on 10-15 1944.

Immediate cause of death	Duration
(a) Convulsions	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Nathan E Christ M.D.

Address St Joseph's Hospital Date signed 10/20/44

D21849 D21849.

BALTIMORE CITY HEALTH DEPARTMENT Registered No.

CERTIFICATE OF DEATH 93E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. St Joseph's Passionist Monastery
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Father Francis Murrmann C.P.
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. S
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 9/16/70
8. AGE: Years 74 Months 1 Days 6 If less than one day hr. min.
9. Birthplace Pittsburg Pa (Town, county, and state)
10. Usual Occupation Roman Catholic Priest
11. Industry or business
FATHER 12. Name John Murrmann
13. Birthplace Unknown
MOTHER 14. Maiden Name Margaret Lane
15. Birthplace Unknown
16 (a) Informant Very Rev. Agatho Durkin C.P.
(b) Address 3000 Fredrick Ave
17 (a) Burial (b) Date thereof 10-24-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Pittsburg Pa
18 (a) Funeral director Geo. A. Farley
(b) Address Fulton & Fayette
19 (a) (b)
(Date rec'd by registrar) Registrar
OCT 24 1944 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/44 19 at 8:15 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 19 44 to 10/22/44 19, and that I last saw him alive on 10/22/44 19

Immediate cause of death	Duration
Acute Congestive Heart Failure	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Frances L. Grumbine M. D.
Address Date signed

VANZANT

G21850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186 G21850

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4109 Echo Dale Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Vanzant

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Alexandria

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 30, 1891

8. AGE: Years 53 | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Kent County, Md. (Town, county, and state)

10. Usual Occupation Hardwood Finisher

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs Alexandria Vanzant
(b) Address 4109 Echodale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge Memorial Park
Location Wash. Blvd.

18 (a) Funeral director J. J. Ruck
(b) Address 5305 Harford Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1944, at 12:27 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15 1944 to 10/23 1944, and that I last saw living alive on 10/23 1944.

Immediate cause of death	Duration
Edema	
Due to Congestive Failure	
Due to Arteriosclerosis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 27/1
(a) Accident, suicide, or homicide
(b) Date of occurrence 10/15/44 at 2:20 A.M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Harris L. Wallace M. D.

Address 1440 N. Carey Date signed 10/23/44

Approved: Robert Lee Graham M.D. 10/23/44

G21851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 830a

G21851
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 57 days
(e) Length of stay in Baltimore (yrs., mos., or days) ——

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1741 Montpelier Ave.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Florence Michael

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Robert Michael
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) 9/19/1884

8. AGE: Years	Months	Days	If less than one day
60	1	2	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name William Malcolm
13. Birthplace Maryland

MOTHER
14. Maiden Name Fannie Johnson
15. Birthplace Maryland

16 (a) Informant Miss Gwendolyn Michael
(b) Address 1741 Montpelier St.

17 (a) Burial (b) Date thereof 10/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem. Perpetual Location Balto., Md.

18 (a) Funeral director HENRY TARRING & SONS
(b) Address Aberdeen, Md.

19 (a) OCT 22 1944
(Date received by Registrar) Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1944, at 4:37 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1944, to Oct 21 1944, and that I last saw her alive on Oct. 21 1944

Immediate cause of death Cerebral hemorrhage — Duration 64 days

Due to Hypertension & arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. Carl Eberling M. D.
Address Univ. Hosp. Date signed 10-24-44

G21852

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

G21852
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2604 Francis St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Francis St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET (MAGGID) L. WINTER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Frank J. Winter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1866

8. AGE: Years 77 | Months 11 | Days 15 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name ? Fuller
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace "

16 (a) Informant Mrs. Joseph Crouse
(b) Address 2604 Francis St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) OCT 23 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1944, at 4:45 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 1943 to Oct 21 1944 and that I last saw h. alive on Oct 20 1944.

Immediate cause of death	Duration
Hemorrhage of cerebral arteries sclerosis (Heart failure)	10 yrs
Due to Illness in bed	1 week
Due to Hypertension	prob
Other conditions Old age	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Abbey M. D.
Address 2307 Eutaw Place Date signed Oct 23-44

VS 150

Oct 23 1944 Thomas Williams, M.D.

G21853

G21853

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1246

XAg-90111

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution: BALTIMORE CITY HOSPITALS 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2100 W. Lanvale Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar Glenn Gosnell

3 (b) If veteran, name war --
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1889

8. AGE: Years 55 | Months 7 | Days 15 | If less than one day: hr. min.

9. Birthplace Maryland (Granite, Balto. Co.)
(Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Von Heine Coal Co.

FATHER
12. Name William R. Gosnell
13. Birthplace Md. (Balto. Co.)

MOTHER
14. Maiden Name Mary R Bailey
15. Birthplace Md. (Balto. Co.)

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/44 (month) (day) (year)
(c) Cemetery or crematory Balto. Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 23 1944 (b)
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22 1944, at 4:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-6 1944, to 10-22 1944 and that I last saw h.. alive on 10-22 1944

Immediate cause of death	Duration
Lung insufficiency	3 mo.?
Due to Portal Circulation of Liver	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Dr Post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. M. Pillsbury M. D.
Address Balto. City Hosp. Date signed 10-22-44

Pending for Histological report

G8135-4 BALTIMORE CITY HEALTH DEPARTMENT G8135-4

CERTIFICATE OF DEATH 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkens
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Park Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. MARGARET T. C. LEAVERTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	widowed

6 (b) Name of husband or wife Gary H.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 14, 1872

8. AGE: Years	Months	Days	If less than one day
72	1	7	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Hunt
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret ?
15. Birthplace Germany

16 (a) Informant Mr. Robert H. Coleman
(b) Address 106 Park Drive, Catonsville, Md.

17 (a) Burial (b) Date thereof 10/24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Informant's) (b) Registrar
Registered OCT 25 1944

VS-186

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21 1944, at 2:20 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-30 1944, to 10-24 1944 and that I last saw her alive on 10-21 19 44

Immediate cause of death Degeneration C-V disease — Duration

Due to

Due to

Other Conditions Fractured femur Bronchitis acid
(Include pregnancy within 3 months of death)

Date of operation 9-22-44

Major findings of operation: Subtro-chanteric osteotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence 9-30-44 at M
(c) Where did injury occur? 106 Park Road Catonsville (County) Md. (State)
(d) Did injury occur about home, on farm, industrial place, in public place? No (Specify type of place) While at work? no
(e) Means of injury Fell down the stairs

23. Signature Howard J. Stein M. D.
Address St Agnes Hosp. Date signed 10-24-44

Approved: Howard J. Stein M.D.
per Robert Le Frois M.D. 10/24/44

G21855 BALTIMORE CITY HEALTH DEPARTMENT G21855

CERTIFICATE OF DEATH 1220

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens + Caton Ave.
(c) Hospital or institution: St. Agnes Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 5
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3210 Rosalie Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Florence L. Kirby

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife T. Havard Kirby
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 4 - 1888

8. AGE: Years	Months	Days	If less than one day
56	8	18	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Wm. Blakely (decd)
13. Birthplace Md Baltimore

MOTHER
14. Maiden Name Sara Smith (decd)
15. Birthplace Md

16 (a) Informant Mrs. John Noll
(b) Address 7703 Queen Anne Dr.

17 (a) Burial (b) Date thereof Oct 23 - 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore Md.

18 (a) Funeral director Francis Cook-Lyke
(b) Address 1600 W. North Ave

19 (a) OCT 23 1944 for Williams
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1944, at 10:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1944 to 10/22 1944, and that I last saw h[illegible] alive on 10/22 1944.

Immediate cause of death	Duration
Peritonitis	
Due to Ruptured bowel	
Due to	
Other Conditions Diaphragmatic hernia	

(Include pregnancy within 3 months of death)

Date of operation 10-17-44
Major findings of operation: Inguinal gland biopsy
of autopsy: Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stur M. D.
Address St Agnes Hosp Date signed 10-22-44

VS 150

G21856

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21856 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 204 E. 22nd St
(c) Hospital or institution: 12-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 204 E. 22nd St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Hamilton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months — | Days — | If less than one day: hr. min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles McDonough
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Lally
15. Birthplace Ireland

16 (a) Informant Mrs. C. Dolan
(b) Address 204 E. 22nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 27 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location

18 (a) Funeral director Mary M Wiedefeld
(b) Address 501 E. 22nd St.

19 (a) (Date received by registrar) (b) Hunting Park Register

VS OCT 23 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 20 1944, at 8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/1 1944 to 10/20 1944 and that I last saw h... alive on 10/20 1944

Immediate cause of death: Myocardial Insufficiency — Duration: 4 hrs
Due to: Myocarditis — 1 yr
Due to: Pneumonia Lobar Bronchitis — 10 ds
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Thomas J White M. D.
Address 582 E. 22nd St Date signed 10/23/44

G21857

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G21857 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 510 E. 23rd St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-8
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 510 E. 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Goldrick Dunn

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1877
8. AGE: Years 67 | Months — | Days — | If less than one day hr. min.
9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Martin Goldrick
13. Birthplace Ireland

MOTHER
14. Maiden Name Catherine Boyle
15. Birthplace Ireland

16 (a) Informant Julia Dunn
(b) Address 510 E. 22nd St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location —
18 (a) Funeral director Mary M. Woodfield
(b) Address 501 E. 22nd St
19 (a) OCT 23 1944 (Date received by registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/21/1944, at 9a M
21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1944, to Oct 21 1944, and that I last saw h. alive on 10/21 1944.

	Duration
Immediate cause of death: Bronchopneumonia	2 days
Due to: Hypostatic	1 year
Due to: Secondary Carcinoma due to probable malignancy	2 yrs
Other Conditions: Chronic Cystitis & Prostatism	2 years

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury —
23. Signature Thomas J. White M. D.
Address 502 E 22nd St Date signed 10/23/44

G21858

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21858 Registered No. 170 C

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1010 arlington ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas Jackson

3 (b) If veteran, name war –

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 68 | Months | Days – | If less than one day hr. min.

9. Birthplace Centerville, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Basil Jackson
13. Birthplace Maryland

MOTHER
14. Maiden Name Sarah ??
15. Birthplace Unknown

16 (a) Informant Mary E. Jackson
(b) Address 1010 N. Arlington Ave

17 (a) Burial (b) Date thereof Oct. 25 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md

18 (a) Funeral director Mrs. Lee A. Holland
(b) Address 1631 Druid Hill Ave

19 (a) OCT 22 1944 (b) Kathryn Williams Registrar
(Date rec'd by registrar)

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20- 1944, at 7:10 P M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Ruptured Heart.

Due to

Other Conditions Fractured ribs; Internal Hemorrhage Lacerations etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-20- at 16/1 7P M.
(b) Where did injury occur? Fremont Ave & Winchester St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Pedestrian struck by Automobile

23. Signature Howard J. Mussens M.D.
Medical Examiner.
Date signed 10-21-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21859

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163B

Registered No. G21859

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address: Provident Hospital

(c) Hospital or institution: 1614 Division St. Baltimore

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 T

(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town 1040 W. 42nd Street (If outside city or town limits, write RURAL and give town)

(d) Street No. Gelcimore (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Verline Lampkin Davenport

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1, 1923

8. AGE: Years	Months	Days	If less than one day
21	3	20	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name Adolphus Lampkin

13. Birthplace Virginia

MOTHER

14. Maiden Name Ora Cornegy

15. Birthplace Virginia

16 (a) Informant Hazel Cornegy

(b) Address 1010 W. 42nd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/24/44 (month) (day) (year)

(c) Cemetery or crematory Lillian Va

Location Lillian Va

18 (a) Funeral director Geo. B. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) (Date received by registrar) OCT 23 1944 Huntington Williams, M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21, 1944, at 1:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 16, 1944 to Oct 21 1944, and that I last saw h.. alive on Oct. 21 1944.

	Duration
Immediate cause of death: Myocardial Insufficiency	
Due to: Thyrotoxicosis	
Due to: Toxic Goitre	3 months
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation Oct 20 1944

Major findings of operation: Enlarged Thyroid

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. Bradshaw Triggs M. D.

Address 2743 Madison Ave Date signed 10/23/44

G21860

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48a

G21860 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green St
(c) Hospital or institution:
Univ Hosp
(d) Length of stay in hospital or inst. (yrs., mos. or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town 633 Annesley Road.
(If outside city or town limits, write RURAL and give town)
(d) Street No. Annesley Maryland
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Kendall (Jewes)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Robert Kendall

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 6, 1902

8. AGE: Years	Months	Days	If less than one day
42 yrs.	3	14 15	hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name William Gill
13. Birthplace Maryland

MOTHER
14. Maiden Name Annie Rockstopper
15. Birthplace Maryland

16 (a) Informant Mrs Mildred Jane Kendall
(b) Address 623 Annesley Rd Towson Md

17 (a) Burial (b) Date thereof 10/24/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Woodland Park
Location Taylor ave

18 (a) Funeral director Howard A. Gill
(b) Address 19 W. Penna Ave, Towson

19 (a) OCT 23 1944 Registrar
(Date received by local registrar)

Huntingdon Pennsylvania, Md

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH [redacted] 10-21 1944, at 330 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 20 1944, and that I last saw her alive on Oct. 20 1944

Immediate cause of death

Due to Carcinoma of the Cervix

Due to Frozen pelvis and bilateral hydroureter

Other Conditions Lymphomyosis.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Ca of Cervix Grade IV

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Homer L Wilson M. D.
Address Date signed 10-21-44

G21861 DAGUET. G21861

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rayner & Dukeland
(c) Hospital or institution: W. Balto General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2661 Danway Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Daguet

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W.	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1944

8. AGE: Years	Months	Days	If less than one day
		2	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Allen Daguet
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Sarah Richman
15. Birthplace Balto Md.

16 (a) Informant L. Nigh
(b) Address W.B.G.H.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 23 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 23 1944 (Date rec'd by registrar) (Signature) Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-22 1944, at 12:40 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1944, to 10-22 1944, and that I last saw him alive on 10-22 1944.

Immediate cause of death	Duration
Cardiac - Respiratory Failure	
Due to Prematurity	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Edward C. Day M. D.
Address W.B.G.H. Date signed 10/23/44

V8 150

2251

G21862

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

830 Registered No. G21862

PLEASE WRITE PLAINLY, WITH INK AND DO NOT ABBREVIATE. Use no ditto marks. Answer all questions fully and correctly. Where there is no entry, write NONE. Where unknown, so state. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1008 Russell Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 21
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1008 Russell Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Bessie A. Gaskill

3 (b) If veteran, name war –
3 (c) Social Security Account No. –

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Wolseton Gaskill
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 28, 1874

8. AGE: Years 69 | Months 9 | Days 20 2-3 | If less than one day hr. min.

9. Birthplace Baltimore Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Thomas Flynn
13. Birthplace Ireland

MOTHER
14. Maiden Name Margaret
15. Birthplace Ireland

16 (a) Informant Wolseton Gaskill
(b) Address 1008 Russell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24, 1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Flynn & Fleming
(b) Address 1426 Light Street

1944 OCT 22 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1944, at 9:30 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral Hemorrhage, spontaneous

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed October 20, 1944.

G21863

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 479

G21863 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 5 4
(e) Length of stay in Baltimore (yrs., mos., or days) 7 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 134 Patapsco ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lottie R. Green LOTTIE R. GREEN

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Geo. E. Green deceased 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22 - 1894

8. AGE: Years	Months	Days	If less than one day
49 50	11	28	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Pannell Richards
13. Birthplace Va

MOTHER
14. Maiden Name Eliz. Finden
15. Birthplace Va.

16 (a) Informant Evelyn Walters
(b) Address 136 Patapsco Ave. Dundalk

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 23-44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave. Rd.

18 (a) Funeral director John J. Connelly
(b) Address 418 Eastern Ave Essex

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

OCT 23 1944

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-19-44 19 , at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-12 1944, to 10-19 1944 and that I last saw h[illegible] alive on 10-19 1944

Immediate cause of death Uremia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-19-44

Major findings of operation: Muscle Biopsy

of autopsy: yes - Fibroid of uterus

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hospital Date signed 10-19-44

G21864

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G21864 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A. Co.
(c) City or town Green Haven
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena, Md.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Leary

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-44

8. AGE: Years | Months | Days: 2 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Abraham Leary
13. Birthplace W. Va.

MOTHER 14. Maiden Name Cauling
15. Birthplace W. Va.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 24 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 24 1944 (Date rec'd by registrar) (Signature) Lemuel Lee Williams, M.D. Registrar

VS 180

2252

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 18 1944 at 8:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 16 1944 to Oct 18 1944 and that I last saw h.er alive on Oct. 18 1944

Immediate cause of death — Duration

Premature 3 months

Due to

anuria

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Anatomical Diag. 10/19/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clifton D. Gaines Jr. M. D.
Address Date signed

G21865

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G21865

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15-14 Division St
(c) Hospital or institution: Provident Hospital 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 hrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Lauren St (If rural give location)
(e) Citizen of foreign country? Nat (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boone

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-14-44

8. AGE: Years | Months | Days | If less than one day: 8 hrs., min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Daniel Boone
13. Birthplace Wilson N.C.

MOTHER
14. Maiden Name Rosa White
15. Birthplace Johnson County N.C.

16 (a) Informant Daniel Boone
(b) Address 302 Lauren St.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 24 1944

18 (a) Funeral director Commissioner of Health
(b) Address

OCT 24 1944 (Date rec'd by registrar) by Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14-1944, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 2 P.M. 10-4-44 19 to 10 A.M. 10-14-44 19 44, and that I last saw he alive on 10-14-44 19

Immediate cause of death: Premature Birth 5 m — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature

Address 605 N Fremont Ave Date signed 10-14 M. D.

VS 150

2253

G21866

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 161 Registered No. G21866

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6517 Vincennes Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6519 Vincennes Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Baby Charles Kilian Albert Jr.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-2-44

8. AGE: Years — | Months — | Days 21 | If less than one day hr. min.

9. Birthplace Frederick, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Charles K. Albert

13. Birthplace Baltimore, Md.

MOTHER 14. Maiden Name Josephine Woods

15. Birthplace Brunswick, Md.

16 (a) Informant Charles F. Albert

(b) Address 6517 Vincennes Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md

18 (a) Funeral director Loring Byram

(b) Address 502 N. Eutaw

19 (a) (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Oct. 23 1944 at 11 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Erythroblastosis Fetalis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Robert Lee Graham M.D. (Medical Examiner.)

Date signed Oct. 23 1944

Please write the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2943 39 — BALTIMORE CITY HEALTH DEPARTMENT — 24867

CERTIFICATE OF DEATH 309

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Harford
(c) City or town Belair (If outside city or town limits, write RURAL and give town)
(d) Street No. 121 N. Bond St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Thomas Mc Phatter

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Leola | 6 (c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) 5-12-02

8. AGE: Years 42 | Months 5 | Days 9 | If less than one day ___ hr. ___ min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER 12. Name J. E. Mc Phatter
13. Birthplace N. C.

MOTHER 14. Maiden Name Dinna Wilkinson
15. Birthplace N. C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10 23 44 (month) (day) (year)

(c) Cemetery or crematory Location Bel-air Md

18 (a) Funeral director Eleanor Beck
(b) Address 556 Lewis N-de-L Md

19 (a) 24 1944 (Date rec'd by registrar) (b) Hunter Register

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-21- 1944, at 5-15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18-1944, to 10-21-1944, and that I last saw him alive on 10-21-1944.

Immediate cause of death cardiac failure

Due to Syphilitic aortitis & aortic insufficiency

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon

Address Johns Hopkins Hosp. Date signed 10-24-44

G21868 G21868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

469

1. PLACE OF DEATH — Registered No.

CITY OF BALTIMORE: (No. 810 Burgundy St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Gustave F. Winters — If U. S. Veteran specify WAR

(a) Residence: No. 810 Burgundy St. 21 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

3a. If married, widowed or divorced: HUSBAND of (or) WIFE of Lena Winters

6. DATE OF BIRTH (month, day, year): July 4th 1873

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	3	18	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Sheet Metal Worker

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Conn

FATHER

13. NAME (Unknown) Winters

14. BIRTHPLACE (city or town) (State or country) Germany

MOTHER

15. MAIDEN NAME "

16. BIRTHPLACE (city or town) (State or country) "

17. INFORMANT Lena Winters
(Address) 810 Burgundy St.

18. BURIAL, CREMATION, OR REMOVAL
Western Burial Date 10/25 1944

19. UNDERTAKER William Cook Inc
(Address) 127 E. Baud St.

20. FILED 19 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 22nd, 1944

22. I HEREBY CERTIFY, That I attended deceased from 8-9-44, 19 to 10-22, 19 44

I last saw him alive on 10-22, 19 44. Death is said to have occurred on the date stated above, at 4:10 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Acute Cardiac Failure	10th
Carcinoma of Head & Pharynx metastatic	2yr
Other contributory	

Was an operation performed? Date of

For what disease or injury?

Name of operation

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If

(Signed) Joseph G. Lankatis M.D.

(Address) 679 Washington Blvd

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 8

G21869 **HEALTH DEPARTMENT—CITY OF BALTIMORE** G21869

CERTIFICATE OF DEATH 97

Registered No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH
CITY OF BALTIMORE: (No. 2502 Kenoak Rd St., ... Ward)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Clara R. Roe — If U. S. Veteran specify WAR .....

(a) Residence: No. 2502 Kenoak Rd St., 27-19 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of William N. C. Roe

6. DATE OF BIRTH (month, day, year) May 12th 1859

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
85	5	10	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. At Home
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. —
10. Date deceased last worked at this occupation (month and year) — 11. Total time (years) spent in this occupation —

12. BIRTHPLACE (city or town) Balto (State or country) Md.

FATHER
13. NAME Harry Raybold
14. BIRTHPLACE (city or town) (State or country) Pa

MOTHER
15. MAIDEN NAME Clara Underwood
16. BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

17. INFORMANT Mrs Mary Kohl
(Address) 2502 Kenoak Rd

18. BURIAL, CREMATION, OR REMOVAL Druid Ridge Date 10/24, 19 44

19. UNDERTAKER Wilkerson Cook Inc
(Address) 1217 St. Paul St

20. FILED ..... 19.... ..... Registrar.

OCT 24 1944 Druid Ridge Cem

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 22nd, 1944

22. I HEREBY CERTIFY, That I attended deceased from Oct 21 19 44 to Oct-22 19 44

I last saw her alive on Oct-22 19 44. Death is said to have occurred on the date stated above, at 12 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Senility	
Other contributory causes of importance: Arteriosclerosis	

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ..... 19.....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....

(Signed) Samuel H Cohen M. D.
(Address) 5611 Reisterstown Rd

INFORMATION REQUIRED BY STATISTICAL BUREAU. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

G21870

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21870

CERTIFICATE OF DEATH 937

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 3612 Milford Ave Ward)

Length of residence in city or town where death occurred ... yrs. ... mos. ... da. How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

2. FULL NAME Joshua Jones

If U. S. Veteran specify WAR.....

(a) Residence: No. 3612 Milford Ave, 28th Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Jones

6. DATE OF BIRTH (month, day, year) Oct 7th 1854

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
90	0	15 16	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Nicholas Jones

14. BIRTHPLACE (city or town) (State or country) Unknown

MOTHER

15. MAIDEN NAME Mary Leaf

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Rebecca Jones
(Address) 3612 Milford Rd

18. BURIAL, CREMATION, OR REMOVAL
Place Lorraine Date 10/26 1944

19. UNDERTAKER Wm Cook Inc
(Address) 1217 St. Paul St

20. FILED ..... 19.... ..... Registrar.

OCT 24 1944

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 23rd 1944

22. I HEREBY CERTIFY, That I attended deceased from Sept 1940 to Oct 23rd 1944.

I last saw him alive on Oct 5th 1944. Death is said to have occurred on the date stated above, at 8 a.m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arterio - Sclerotic Heart Disease	10 yrs?
Other contributory causes of importance: Senile Debilities	5 yrs

Was an operation performed? No Date of .....

For what disease or injury? .....

Name of operation .....

What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ..... 19....

Where did injury occur? .....
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place .....

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No. If so, specify .....

(Signed) Fred L. Chamberlin M. D.

(Address) 1108 Liberty Hts. Ave.

INFORMATION BEFORE BE CAREFULLY SUPPLIED. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

21871 21871 G21871

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 570

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Gouverneur Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Rural - Parkville (If outside city or town limits, write RURAL and give town)
(d) Street No. Beverly Rd. Parkville (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Koch

3 (b) If veteran, name war: H

3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (if day unknown, state) Sept 18 1929

8. AGE: Years	Months	Days	If less than one day
15	1	5	hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Student

11. Industry or business

FATHER: 12. Name Henry Koch
13. Birthplace Md.

MOTHER: 14. Maiden Name Louise Martin
15. Birthplace Germany

16 (a) Informant Records
(b) Address University Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Parkville Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 24 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23 1944, at 2:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1944, to 10-23 1944, and that I last saw him alive on 10-23 1944.

Immediate cause of death: Internal hydrocephalus — Duration

Due to: Brain tumor

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-22-44

Major findings of operation: Increased intracranial pressure

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Otto R. Ewing, M.D.
Address Univ. Hosp. Date signed 10-23-44

G21872 OCTORARY NORMAN ✓ G21872

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No.

Every item of information should be carefully supplied. Write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2661 Frederick Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 5
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2661 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Octonary L. Norman

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex: Female — 5. Color or race: White — 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Ed. N. Norman — 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 29th 1883

8. AGE: Years 60 | Months 9 | Days 2 | If less than one day: hr. min.

9. Birthplace Lonaconing, Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER — 12. Name John McNorman — 13. Birthplace Md

MOTHER — 14. Maiden Name — 15. Birthplace Md

16 (a) Informant Mrs Virginia L. Norman — (b) Address 2661 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) — (b) Date thereof 10/24/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park — Location Baltimore, Md

18 (a) Funeral director J. B. Hartsuff & Son — (b) Address 800 Eutaw Place

19 (a) (Date rec'd by registrar) — (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24th 1944 at 5:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-6 1944 to Oct-21 1944 and that I last saw h[illegible] alive on Oct-21 1944.

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Cerebral Hemorrhage	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Samuel Levenberg M.D.
Address 2661 Mehard Ave Balto Md Date signed 10/25/44

VS 189

G21873

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G21873

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6420 Reisterstown Road
(c) Hospital or institution:
Mount Hope Retreat
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-9-17 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 513 Richard + Belvidere St. Mary's Seminary (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Rev. Edward A. Gilgan, S.S.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1873

8. AGE: Years	Months	Days	If less than one day
71	4	29	hr. min.

9. Birthplace New York (Town, county, and state)

10. Usual Occupation Priest

11. Industry or business

FATHER
12. Name John Joseph Gilgan
13. Birthplace

MOTHER
14. Maiden Name Agnes Letetia Malone
15. Birthplace

16 (a) Informant Mount Hope Retreat
(b) Address 6420 Reisterstown Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/44 (month) (day) (year)
(c) Cemetery or crematory St. Charles
Location Catonsville, Md.

18 (a) Funeral director H. W. Meyers and Son
(b) Address 502 N. Calvert St.

19 (a) OCT 24 1944 (Date rec'd by registrar) (b) Huntington Williams, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 4 1938, to Oct 23 1944, and that I last saw h[illegible] alive on Oct 23 1944

Immediate cause of death	Duration
Repeated coronary thrombus	2 yrs
Due to	
Due to	
Other Conditions Paranoid psychosis	6 yrs.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Dagmar P. Hayes M. D.
Address 33 E. Mulberry St. Date signed

VS 3

G21874

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48B

G21874 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5 E. Mt. Royal Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11-2
(e) Length of stay in Baltimore (yrs., mos., or days) Over 25 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5 E. Mt. Royal Avenue (If rural give location)
(e) Citizen of foreign country? ------ (Yes or No) If yes, name country ------

3 (a) FULL NAME Anna Judge Spitznagel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William F. Spitznagel
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years: About 45 | Months: --- | Days: -- | If less than one day: -- hr. --- min.

9. Birthplace: Brooklyn, New York (Town, county, and state)

10. Usual Occupation: -------

11. Industry or business: -------

FATHER
12. Name: Not obtainable
13. Birthplace: Not obtainable

MOTHER
14. Maiden Name: Not obtainable
15. Birthplace: Not obtainable

16 (a) Informant: William F. Spitznagel
(b) Address: 5 E. Mt. Royal Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Baltimore, Maryland

18 (a) Funeral director: H. W. Meares and Son
(b) Address: 805 N. Calvert Street

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

OCT 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 1943 to Oct 22 1944, and that I last saw h alive on Oct 21 1944

Immediate cause of death: Cardiac failure — (Duration)

Due to: Carcinoma of uterus & bladder —

Due to:

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Wilford G Connell M. D.
Address: 9 E Mt Royal Ave Date signed: 10/23/44

G21875 BALTIMORE CITY HEALTH DEPARTMENT G21875
CERTIFICATE OF DEATH 469 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2122 Eagle st
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2122 Eagle st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Kashtett
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife Late Simon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1884
8. AGE: Years 60 Months Days If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business House Wife
FATHER 12. Name Samuel Pikofsky
13. Birthplace Russia
MOTHER 14. Maiden Name Goldie ?
15. Birthplace Russia
16 (a) Informant Joseph Kashtett
(b) Address 2122 Eagle st
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Herring Run
Location Bowleys Lane
18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W Northwood
19 (a) (Informant) (b) Huntington Hillsboro, Md.
OCT 24 1944
VS 150

MEDICAL CERTIFICATION
20. DATE OF DEATH October 23 1944 at 6 P. M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 1943 to Oct 23 1944 and that I last saw her alive on 10/23 1944
Immediate cause of death Carcinoma of Pancreas (Head)
Duration 1 yr
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Benjamin Miller M. D.
Address 2036 Wilkens Ave Date signed 10/23/44

B89308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. G21876

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 903 W. 32nd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carolyn Ward

3 (b) If veteran, name war | (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-17-44

8. AGE: Years | Months: 8 | Days: 5 | If less than one day: hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Charles Ward
13. Birthplace Md

MOTHER 14. Maiden Name Dorothy Rinehart
15. Birthplace Md

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Oct 24/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Taylor Ave

18 (a) Funeral director Ellenwood & Donovan
(b) Address 3615 Chestnut Ave.

19 OCT 24 1944 Huntington Williams, M.D.
(Date received by registrar) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 19 , at 8:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1 19 44 to Oct 22 19 44 and that I last saw h[illegible] alive on Oct 22 19 44.

Immediate cause of death Uremia ?

Due to urinary tract infection

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard A. Kelly M. D.
Address Johns Hopkins Hospital Date signed Oct 24 1944

G21877

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

30 D

✓ G21877 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp. 14
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore 3
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2034 Druid Hill Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Russell Guilford

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-10-9862

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5 1898

8. AGE: Years 46 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Aurora, N.C.
(Town, county, and state)

10. Usual Occupation Waiter

11. Industry or business

FATHER 12. Name John Guilford.
13. Birthplace Aurora, N.C.

MOTHER 14. Maiden Name Alice Guilford
15. Birthplace Aurora N.C.

16 (a) Informant Mrs. Edw. Davis
(b) Address 2034 Druid Hill Ave.

17 (a) Burial (b) Date thereof 10-25-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director A. A. Gaddis
(b) Address 2101 Mt. Lollard St.

19 (Date rec'd by registrar) OCT 24 1944 Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1944, at 7 10 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Ruptured aneurysm of Aorta

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Emerson Graham M.D.
Medical Examiner.
Date signed Oct. 20 1944

Please write plainly, using ink. Do not use pencil. Do not abbreviate. Be sure to answer all questions. Be sure the cause of death is correctly stated. Be sure the cause of death is clearly and legibly. correct age is especially important. Physicians: please write the

G21878

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G21878 Registered No.

1. PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hosp. 7
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. O. A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County 4
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Mc Donough St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Woolford

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 78 | Months | Days | If less than one day ___ hr. ___ min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Batholomy Woolford
13. Birthplace Worchester co. Md.

MOTHER
14. Maiden Name Mariah A. Thomas
15. Birthplace Worchester co. Md.

16 (a) Informant Loretta Chester
(b) Address 1138 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. Md.

18 (a) Funeral director Raymond Wright
(b) Address 721 Biddle St

19 (a) OCT 24 1944 (Date rec'd by Registrar) Arthur Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 19 1944, at 1 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert A. Gunter M.D.
Medical Examiner.
Date signed Oct. 19 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21879 BALTIMORE CITY HEALTH DEPARTMENT G21879

CERTIFICATE OF DEATH 54B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Sts.
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Pr. Geo's.
(c) City or town Fruitland
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Betts

3 (b) If veteran, name war: V
3 (c) Social Security Account No.:

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Arlan Betts
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) March 8, 1902

8. AGE: Years 42 Months 7 Days 15 If less than one day ____ hr. ____ min.

9. Birthplace Maryland (Town, county and state)
10. Usual Occupation Housewife
11. Industry or business Home

FATHER
12. Name George Price
13. Birthplace Md.

MOTHER
14. Maiden Name Estella Krouse
15. Birthplace Md

16 (a) Informant Husband
(b) Address Fruitland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)
(c) Cemetery or crematory Nebraska
Location Sykesville, Md.

18 (a) Funeral director Pete Hill Funeral Home
(b) Address Salisbury, Md.

19 (Date rec'd by registrar) OCT 24 1944 Huntington-Williams, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1944, at 1:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1944, to 10/23 1944 and that I last saw her alive on 10/23 1944.

Immediate cause of death Cerebral Edema — Duration

Due to Brain Tumor

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operations:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. A. Kroeberg Jr.
Address Univ. Hosp. Date signed M/D. 10/24/44

G21880 ✓G21850

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 63c

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafeyette and John St.
(c) Hospital or institution:
Hospital for the Women of Maryland.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 Fairmount ST., N.W.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Nancy Blue Kuykendall

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 1, 1881

8. AGE: Years	Months	Days	If less than one day
62	10	22	1 hr. 10 min.

9. Birthplace Garrett County, Maryland
(Town, county, and state)
10. Usual Occupation School Teacher, retired
11. Industry or business

FATHER
12. Name Capt. Isaac Kuykendall
13. Birthplace Maryland

MOTHER
14. Maiden Name Lucy Davis
15. Birthplace Virginia

16 (a) Informant Mrs. Frances K. Blue
(b) Address

17 (a) Removal - Burial (b) Date thereof Oct. 24-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Indian Mound
Location Romney, W. Va.

18 (a) Funeral director Burdette Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Huntington Williams, M.D. Address Women's Hospital

OCT 24 1944
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1944, at 10 19 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1944, to 10-23 1944, and that I last saw her alive on 10-23 1944.

Immediate cause of death	Duration
Coronary occlusion	
Due to Arteriosclerotic heart disease	
Due to Arteriosclerosis, generalized	
Other Conditions ? Hyperparathyroidism, ?? Extra pituitary.	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. B. Farrell III M. D.
Address Women's Hospital Date signed 10-23-44

G21881

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G21881 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-12
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 210 Witherspoon Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Hubert J. Titus

3 (b) If veteran, name war: Ford #1
3 (c) Social Security Account No. 082-03-0912

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Isabel M.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-5-92

8. AGE: Years 52 | Months 5 | Days 18 | If less than one day hr. min.

9. Birthplace Ohio (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business Palmer Corp.

FATHER
12. Name Forest M. Titus
13. Birthplace Ohio

MOTHER
14. Maiden Name Mabel Hagberger
15. Birthplace Pa

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal & Burial (Burial, cremation, or removal) (b) Date thereof Oct. 25. 1944 (month) (day) (year)
(c) Cemetery or Crematory Cedar Lawn
Location Patterson, L. I.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (Date rec'd by registrar) (b) Huntington Williamson, M.D.

OCT 24 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1944 at 5:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 19 1944 to Oct. 23 1944 and that I last saw h[illegible]alive on Oct 23 1944.

Immediate cause of death Anoxia, due to heart failure and pulmonary embolis — Duration

Due to Coronary occlusion +

Due to Femoral thrombo-phlebitis, right

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ross L. McLean M. D.
Address J. H. H. Date signed 10-4-44

24882

YA-90805

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21882 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3802 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillie ~~Gaede~~ or Lillie Gaede

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	?

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, ? ? 87

8. AGE: Years	Months	Days	If less than one day
65?	?	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Robert Gaede
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary ?
15. Birthplace Baltimore

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address R (RECORDS)

17 (a) Burial (b) Date thereof Oct 24 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Sellers Funeral Home
(b) Address 2004 E. Oliver St

19 (a) (Date received by Registrar) OCT 24 1944 Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1944, at 2:00A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1944 to 10-20 1944 and that I last saw h[illegible] alive on 10-20 1944

Immediate cause of death Diabetic Acidosis.

Duration Unknown

Due to Diabetes.

Due to Pneumonia.

Other Conditions.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Raymond L. Erickson M. D.

Address 4948 Eastern Ave. Date signed 10/21/44

Thurlington Williams, M.D

G21883

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G21883

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 412 Southway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 412 Southway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Augusta Poindexter Miller

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Colored	Married ?

6 (b) Name of husband or wife Ernest
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-25-1886

8. AGE: Years	Months	Days	If less than one day
57 58	9	26	hr. min.

9. Birthplace Wash. D.C. (Town, county, and state)
10. Usual Occupation Domestic
11. Industry or business

FATHER
12. Name John Poindexter
13. Birthplace Eastern, Va.

MOTHER
14. Maiden Name Emma Barrett
15. Birthplace Eastern, Va

16 (a) Informant Malcom J. Lyon
(b) Address 412 Southway

17 (a) Burial (b) Date thereof Oct 24, 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore Co. Md.

18 (a) Funeral director Wm. Chas. A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) (Signature of local registrar)

OCT 24 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1944, at 7 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 29 1944, to Oct 21 1944, and that I last saw h[illegible] alive on Oct 20 1944.

Immediate cause of death Acute Insufficiency — Duration 3 days
Due to Acute Arthritis — 3 mos
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. C. Pettitt M. D.
Address 817 Hamilton Ave Date signed Oct 24/44

G21834 ✓ G21834

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland 12
(c) Hospital or institution:
Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 421 E. 23rd St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE LYNCH

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/10/1915

8. AGE: Years 29 | Months 4 | Days 11 | If less than one day hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Long Shoreman

11. Industry or business

FATHER
12. Name George Lynch Sr
13. Birthplace Va

MOTHER
14. Maiden Name Annie ?
15. Birthplace Va

16 (a) Informant Mary Lynch
(b) Address 421 E. 23rd St

17 (a) Shipped (b) Date thereof 10-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Altavista Va
Location Virginia

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) (b) Huntington Williams, Registrar
OCT 24 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21 1944, at 1:40 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-14-44 3:40 P.M. 12/7
(b) Where did injury occur? Found on Wyman Park Terrace
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes.
(d) Means of injury Has been on end of truck fell off onto street

23. Signature H. L. Williams M.D.
Medical Examiner.
Date signed 10-21-44

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21885

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

G21885 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution:
Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 wk
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4414 St George Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE SCOTT.

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
FEM	Col	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 13-1905

8. AGE: Years	Months	Days	If less than one day
39	11	7	hr. min.

9. Birthplace Lexington N.C
(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

FATHER
12. Name Ike Potter
13. Birthplace NC

MOTHER
14. Maiden Name Unknown
15. Birthplace NC

16 (a) Informant Robert Scott
(b) Address 4414 St George Ave Gwns

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location B.A. Co

18 (a) Funeral director Rayner Sanders
(b) Address 442 E Preston St

19 (a) OCT 24 1944 (Date rec'd by registrar) Huntington Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1944, at 5:10 P.M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Z. Wollammer M.D.
Medical Examiner.
Date signed Oct 24 1944

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G21886

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21886 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 509 South Chester Street
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore-31,
(If outside city or town limits, write RURAL and give town)
(d) Street No. 509 South Chester Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Benjamin F. Latkowski (OR) Bernard Frank Casky

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-10-6037

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) About 1884

8. AGE: Years	Months	Days	If less than one day
60 ?			hr. min.

9. Birthplace Baltimore, Md.?
(Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Michael Latkowski
13. Birthplace Germany

MOTHER
14. Maiden Name Susanna ?
15. Birthplace Unknown

16 (a) Informant Rose Latkowski (Sister)
(b) Address 509 South Chester Street

17 (a) Burial (b) Date thereof 10-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Baltimore, Md.

18 (a) Funeral director George A Weber
(b) Address 705 South Ann Street

19 (a) (b)
(Date received by local registrar)

OCT 24 1944 Huntingtown Hillcrest, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23rd 1944 at 6 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from OCT. 22 1944 to OCT. 23 1944 and that I last saw h/m alive on OCT. 24 1944

Immediate cause of death	Duration
PULMONARY EDEMA	OCT. 23
Due to BRONCHO-PNEUMONIA	OCT. 20
Due to CHRONIC MYOCARDITIS	??
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: —
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jos. F. Veluga M.D.
Address 209 S. Chester St Date signed 10/23/

G21887

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

5 1 B

Registration No. G21887

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Linden & Madison Sts
(c) Hospital or institution: Md. General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days): 9
(e) Length of stay in Baltimore (yrs., mos., or days): Life

2. USUAL RESIDENCE OF DECEASED:
(a) State: Md. (b) County:
(c) City or town: Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No.: 2840 Harford Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country:

3 (a) FULL NAME: WILLIAM HENRY MOORE

3 (b) If veteran, name war: NO

3 (c) Social Security Account No.: NONE

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Lottie Jean Moore

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 17, 1868

8. AGE: Years: 76 | Months: 4 | Days: 4 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Druggist (Ret. 4 yrs.)

11. Industry or business: Drug Store

FATHER
12. Name: John Moore
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Louise Burkert
15. Birthplace: Baltimore, Md.

16 (a) Informant: Miss Louise A. Moore
(b) Address: 2840 Harford Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/24/44 (month) (day) (year)

(c) Cemetery or crematory: Baltimore Cemetery
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Avenue & Broadway

19 (a) Date received by Registrar: OCT 24 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10/21 1944, at 1:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1944, to 10/21 1944, and that I last saw h[illegible] alive on 10/21 1944.

Immediate cause of death: Uremia — Duration: 2 days

Due to: Carcinoma of Prostate — Duration: ?

Due to: — Duration:

Other Conditions: — Duration:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Martin E. Strobel M. D.
Address: Md. Genl. Hospital Date signed: 10/24/44

G21888

JL - 62383

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G21888

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3- 9 -19
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3171 Ravenwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE EDWARD BAUER

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: M
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Margaret Estella
6 (c) If alive, give age: 51 years
7. Birth date of deceased (mo., day, yr.): Nov. 28, 1893
8. AGE: Years: 50 | Months: 10 | Days: 25 | If less than one day: hr. min.
9. Birthplace: Md.
(Town, county, and state)
10. Usual Occupation: None
11. Industry or business

FATHER
12. Name: John Bauer
13. Birthplace: Md.

MOTHER
14. Maiden Name: Barbara Kramer
15. Birthplace: Md.

16 (a) Informant: B. C. H. Records
(b) Address: 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-44 (month) (day) (year)
(c) Cemetery or crematory: Oak Lawn Cemetery
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

OCT 24 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/1944 at 10 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/4 1941 to 10/23 1944 and that I last saw him alive on 10/23 1944

Immediate cause of death: Bronchopneumonia

Due to:

Due to:

Other Conditions: Parkinsonism

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy: no post

Duration: 3-7d.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: C. A. Drury, Jr. M.D.
Address: City Hosp. Date signed 10/24/44

G21889

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 48 B

Registered No. G21889

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 22
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucia Boglia

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 1880

8. AGE: Years 63 | Months 11 | Days 13 | If less than one day hr. min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name John Cosmetto
13. Birthplace Italy

MOTHER
14. Maiden Name Rose Benedetto
15. Birthplace Lettino Rottaro Italy

16 (a) Informant Anthony Boglia
(b) Address 14 N Curley St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director John G Moran
(b) Address 3000 E Baltimore St

CT (a) 2 4 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1944, at 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1944 to Oct 22 1944, and that I last saw h[illegible] alive on Oct 21 1944.

Immediate cause of death Carcinoma of Uterus — Duration 2 years
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence — at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury none

23. Signature L. L. Gourley M. D.
Address 5706 Harford Rd Date signed 10-23-44

VS 180

890

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G21890

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2314 WHITTIER AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 45 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO (If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 WHITTIER AVE (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROSA APPLEBAUM

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOW

6 (b) Name of husband or wife JOSEPH
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years	Months	Days	If less than one day
83			hr. min.

9. Birthplace RUSSIA (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name LEON
13. Birthplace RUSSIA

MOTHER
14. Maiden Name FANNIE
15. Birthplace RUSSIA

16 (a) Informant HARRY SHAVITZ
(b) Address 2314 WHITTIER AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-24-44 (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location Phila RD + HAMILTON AVE

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Balto St

19 (a) OCT 24 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1944, at 11:20 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1933 to Oct 23 1944 and that I last saw h[illegible] alive on Oct 23 1944

Immediate cause of death Coronary Artery Thrombosis — Duration Years

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Meyer B Kyser
Address 2904 Reisterstown Rd Date signed 10/25/44

G21891

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G21891

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Monument St. & Rutland Ave

(c) Hospital or institution Sinai Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12

(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 3455 Cottage Ave (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Dina Levin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Levin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE: Years 83 | Months | Days | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER — 12. Name: Dinder Revkay

FATHER — 13. Birthplace: Poland

MOTHER — 14. Maiden Name: Kielijan

MOTHER — 15. Birthplace: Poland

16 (a) Informant: Dave Levin

(b) Address: 1813 E. Pratt St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-24-44 (month) (day) (year)

(c) Cemetery or crematory: Adas Israel Cong. Cem.

Location: North Point & Germany Hill Rd

18 (a) Funeral director: Joe Levine Inc

(b) Address: 1131 E. Balto St

OCT 24 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1944, at 11.00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1944, to 10/23 1944, and that I last saw her alive on 10/23 1944

Immediate cause of death: Congestive Heart Failure — Duration

Due to: Hypertension — Duration

Due to: Myocardial Failure — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature: Philip H. Lerman M. D.

Address: Sinai Hospital Date signed 10/25/44

G21892

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G21892 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Payson & Dukeland
(c) Hospital or institution:
West Baltimore General Hospital 20-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Balto. md (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 S. Payson St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma Lewman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Moses

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 Months Days If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Eisenberg
13. Birthplace Russia

MOTHER
14. Maiden Name Unknown
15. Birthplace Russia

16 (a) Informant Husband
(b) Address 603 S. Payson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 24 44 (month) (day) (year)
(c) Cemetery or crematory Mores Monteflore
Location Washington Blvd

18 (a) Funeral director Jack Serey Inc
(b) Address 1439 E. Balto. St

19 OCT 24 1944 (Date received by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1944, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1944, to Oct 24 1944, and that I last saw her alive on Oct 24 1944.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Hypertensive Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ruth McBaldwin M. D.

Address West Baltimore Gen'l Hosp Date signed 10-24-44

G21893

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH / 94a

Registered No. G21893

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1910 N. Fulton Ave., City #17 (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME George John Arthur Heim

3 (b) If veteran, name war: none
3 (c) Social Security Account No. 215-09-0700

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Blanche Heim
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	11	hr. min.

9. Birthplace Maryland (Baltimore) (Town, county, and state)
10. Usual Occupation Electrical Contractor
11. Industry or business Self

FATHER
12. Name Andrew Heim
13. Birthplace Maryland

MOTHER
14. Maiden Name Katherine Dober
15. Birthplace Maryland

16 (a) Informant Blanche Heim
(b) Address 1910 N. Fulton, City #17

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/25/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Baltimore, Md.

1944 OCT 24 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1944, at 8:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 9 1944, to October 23 1944, and that I last saw him alive on October 23 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Coronary sclerosis	
Due to Myocardial infarction	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Baumgartner Jr. M. D.
Address 732 E. University Pkwy Date signed 10/23/44

G21894

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No. G21894

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 27
(c) Hospital or institution: South Balto General - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 4621 Kernwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: DAVID W. GLASS, SR.

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 217-18-0227

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florance Haas

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 9, 1888

8. AGE: Years 56 | Months 6 | Days 14 | If less than one day ... hr. ... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Senior Project Eng.

11. Industry or business Federal Hous. Auth.

FATHER
12. Name David Wilson Glass, III
13. Birthplace Norfolk, Va.

MOTHER
14. Maiden Name Eliza Ann Graham
15. Birthplace Balto., Md.

16 (a) Informant Mrs. Florence Glass
(b) Address 4621 Kernwood Ave. 12

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

PLEASE WRITE PLAINLY with unfading black ink. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1944, at 11 A.M.

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereof and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Cerebral Thrombosis

Due to

Other Conditions: Diabetes Mellitus

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Charles J. Salvagio M.D. Medical Examiner.
Date signed 10/23/1944

835

BALTIMORE CITY HEALTH DEPARTMENT X G21895

CERTIFICATE OF DEATH V 117a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 20

2. USUAL RESIDENCE OF DECEASED:
(a) State Kentucky (b) County
(c) City or town Versailles (If outside city or town limits, write RURAL and give town)
(d) Street No. 157 Montgomery St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Wallace Duncan Hamilton

3 (b) If veteran, name war: World War I.
3 (c) Social Security Account No. NONE

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Mrs. Jeannette Hamilton
6 (c) If alive, give age 45 years
7. Birth date of deceased (mo., day, yr.) March 4, 1891
8. AGE: Years 53 | Months 7 | Days 20 | If less than one day hr. min.
9. Birthplace Indiana (Town, county, and state)
10. Usual Occupation Lawyer
11. Industry or business

FATHER
12. Name Mr. Wallace V. Hamilton
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Jean Duncan
15. Birthplace Kentucky

16 (a) Informant wife
(b) Address Versailles, Kentucky

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/24/44 (month) (day) (year)
(c) Cemetery or crematory
Location Versailles Kentucky

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

OCT 24 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/44 1944, at 2:05 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1944, to 10/24 1944, and that I last saw him alive on 10/23 1944.

Immediate cause of death: Cardio-respiratory failure — Duration
Due to: embolism
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation 10/11/44
Major findings of operation: Gastric ulcer
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Mongan Jr. M. D.
Address 332 E. University Pkwy. Date signed 10/24/44

G21896

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓13a

G21896 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1012 W. Lafayette
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 9 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Va. (b) County
(c) City or town Center Cross
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eleanor Jones Melton

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Col.	married

6 (b) Name of husband or wife Hayes Melton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 11, 1876

8. AGE: Years	Months	Days	If less than one day
68	1	9	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Benjamin Jones
13. Birthplace Va

MOTHER
14. Maiden Name Zada Johnson
15. Birthplace Va

16 (a) Informant Sandra Monroe
(b) Address 1012 W. Lafayette

17 (a) Burial, cremation, or removal Date thereof Oct 25-1944
(month) (day) (year)
(c) Cemetery or crematory Center Cross Va
Location Center Cross Va

18 (a) Funeral director Geo T.A. Gibson & Sons
(b) Address 1735 Druid Hill Ave

19 OCT 24 1944 Huntington Williams M.D.
(Date rec'd by registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 20, 1944, at 6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1, 1944 to Oct 20, 1944, and that I last saw h[illegible] alive on Oct 20 1944.

Immediate cause of death	Duration
Cardiovascular Renal Disease	3 months
Due to Cerebral Hemorrhage	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Boulware Higgins M. D.
Address 2273 Madison Ave Date signed 10/27/44

G21897

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1218

G21897

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bryant Fayette 24
(c) Hospital or institution:
Bon Secours

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 503 Lyndhurst St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James T Cain

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Bertie C. nee Pfefferkorn 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 15, 1882

8. AGE: Years	Months	Days	If less than one day
61	10	7	hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Police Officer

11. Industry or business Balto. City

FATHER
12. Name James T. Cain
13. Birthplace Balto. Md

MOTHER
14. Maiden Name Mary E. Carloff
15. Birthplace Balto. Md

16 (a) Informant Mrs. Bertie Cain
(b) Address 503 Lyndhurst St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md

18 (a) Funeral director Harry A Wetzel
(b) Address 1101 E Monument St

19 (a) OCT 24 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/44 19 , at 10:08 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/18/44 19 to 10/22/44 19 , and that I last saw h[illegible] alive on 10/22/44 19

Immediate cause of death Uremia — Duration

Due to Chronic Nephritis — 4 Mo.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: [illegible]

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Grayson S Waldrop. M. D.
Address Bon Secours Hosp. Date signed 10/22/44

VS 150

G21898

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH √121

Registered No. G21898

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Payson St.
(c) Hospital or institution Bon Secours.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20-5
(e) Length of stay in Baltimore (yrs., mos., or days) 6yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2680 Eagle St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Mary Mulledix or Seckford.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Henry C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1909

8. AGE: Years 35 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Frederick County Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Charles Painter
13. Birthplace Md.

MOTHER
14. Maiden Name Unknown
15. Birthplace Md.

16 (a) Informant Mrs. Henry C. Seckford
(b) Address 2680 Edgle St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 25/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md

18 (a) Funeral director Harry A Witzke
(b) Address 4104 Edmondson Ave
(c) Huntington Williams, M.D. (Date received by Registrar) (Registrar)

OCT 24 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1944 at 2 P.M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/13/44 to 10/22/44, and that I last saw h[illegible] alive on 10/22 1944

Immediate cause of death Pulmonary Embolism — Duration 10 days

Due to Post. operative (appendectomy)

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/14/44

Major findings of operation: Gangrenous appendix

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Chas. Norton, Jr. M.D.
Address Bon Secours Hosp Date signed 10/24/44

G21899

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓168

G21899 Registered No.

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore General Hosp. 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) DOA
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1123 S. Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MALACHI A. ~~SPAM~~ M SPAMM

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race Col

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1908

8. AGE: Years 36 | Months | Days | If less than one day hr. min.

9. Birthplace Sumter S. C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name David Spann
13. Birthplace Sumter S.C.

MOTHER
14. Maiden Name Amy Davis
15. Birthplace Sumter S.C.

16 (a) Informant Albert Simm
(b) Address 1123 S Sharp Street

17 (a) Removal (b) Date thereof Oct 24. 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Sumter S.C.
Location —

18 (a) Funeral director Isaiah L Brown Son
(b) Address 1086 Montgomery Street

19 (a) Oct 24 1944 Huntington Williamsport, Md.
(Date rec'd by local registrar) (Signature of local registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 21st 1944; at 12 50 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-21-44 at M.
(b) Where did injury occur? in front of 167-W
(c) Did injury occur at home, on farm, industrial place, in public place? in front of 167 W. Hamburg While at work? no
(d) Means of injury Blunt force

23. Signature J. L. Wollenweber M.D.
Medical Examiner.
Date signed 10-22-44

G21900 G21900

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Baltimore General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 0 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2337 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** John Killealea Killalea

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	White	S

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 27 1883

8. AGE: Years	Months	Days	If less than one day
60	9	27	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Employee of The
11. Industry or business Standard Tea Co.

FATHER
12. Name Joel
13. Birthplace Baltimore

MOTHER
14. Maiden Name Mary J. Wheeler
15. Birthplace Baltimore

16 (a) Informant Mrs. Harry Johnson
(b) Address 2303 Edmondson Ave.

17 (a) B. (b) Date thereof 10-26-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West Cathedral
Location Edmondson Ave

18 (a) Funeral director Rechmel Funeral Home
(b) Address 230 Edmondson Ave

19 (a) OCT 24 1944 Huntington Williams, M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1944, at 5-A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct. 23 1944

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G21901

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92B

G21901 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2102 Cambridge St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2102 Cambridge St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alexandra Zach

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Joseph Zach
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1887

8. AGE: Years	Months	Days	If less than one day
57			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Adam Chlubicki
13. Birthplace Poland

MOTHER
14. Maiden Name Unk.
15. Birthplace Poland

16 (a) Informant Mrs. Sabal
(b) Address 2102 Cambridge St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26/44 (month) (day) (year)
(c) Cemetery or crematory Sacred Heart Of Mary
Location Baltimore

18 (a) Funeral director Fred W. Ozarzurski
(b) Address 1930 Eastern Ave.

19 (a) OCT 24 1944 (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1944, at 5 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11, 1944 to Oct 22 1944 and that I last saw h[illegible] alive on Oct. 19, 1944

Immediate cause of death: Hypertension Cardio-Vascular Renal
Cerebral Hemiplegia
Complicated Senility & Cystitis.
Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony Kurowski M. D.
Address 2529 Eastern Ave. Date signed 10/24/44

G21902

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G21902

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 542 N. Paca St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 542 N. Paca St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Shelby Talgimer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Edmund

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 15, 1907

8. AGE: Years 37 | Months - | Days 5 | If less than one day hr. min.

9. Birthplace Waycross - Ga (Town, county, and state)

10. Usual Occupation House - Wife

11. Industry or business

FATHER 12. Name Tillman Nixon

13. Birthplace Waycross - Ga.

MOTHER 14. Maiden Name Agnes

15. Birthplace Waycross - Ga.

16 (a) Informant Husband

(b) Address -

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 24, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Mrs Katie R Williams

(b) Address 3221 Schroeder St

19 Filed OCT 24 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 20 19 44 at 2:40 PM

21. I certify that death occurred on the date above stated, that I attended deceased from Jan 1944 to Oct. 20 1944 and that I last saw her alive on Oct 18 1944

Immediate cause of death Pulmonary Hemorrhage — Duration

Due to Pulmonary T.B.C. about 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John W Haines M.D.

Address 655 W. Barrett St. signed 10/23/44

G21903

G21903

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-A
(e) Length of stay in Baltimore (yrs., mos., or days) 2½ Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 Ashburton St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Henry H. Russell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Etha W. Russell

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 6, 1875

8. AGE: Years 69 | Months 7 | Days 19 | If less than one day ____ hr. ____ min.

9. Birthplace Reisterstown, Md.
(Town, county, and state)

10. Usual Occupation Checker

11. Industry or business Emerson Hotel

FATHER 12. Name Reuter Russell

13. Birthplace Maryland

MOTHER 14. Maiden Name Julia Decker

15. Birthplace Maryland

16 (a) Informant Etha W. Russell

(b) Address 1800 Ashburton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-44 (month) (day) (year)

(c) Cemetery or crematory All Saints Cemetery

Location Reisterstown, Balto. County, Md.

18 (a) Funeral director Geo. W. Schwab

(b) Address 2101 Frederick Avenue

19 (a) (b) Huntington Williamsport, Md.

Date rec'd by Local Reg. OCT 27 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24- 1944, at 6 45 AM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Coronary Occlusion

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ____ M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 10/28/44

Please write the causes of death clearly and legibly. Physicians: please write in ink; PRINTING WHERE REQUIRED; WITH UNFADING INK. Be sure correct age is especially important.

G21904

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G21904 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1401 Penna Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14-2
(e) Length of stay in Baltimore (yrs., mos., or days) 34yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1401 Penna Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FREDA ROSENBLATT

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Isadore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years 75 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Jerah
13. Birthplace Russia

MOTHER 14. Maiden Name Minni
15. Birthplace Russia

16 (a) Informant Husband
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-24-44 (month) (day) (year)
(c) Cemetery or crematory New York City
Location

18 (a) Funeral director Jack Levin Inc
(b) Address 1439 E. Balto St

OCT 24 1944 (Date rec'd by local registrar) Huntington Williams Mfr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24- 19 , at 47 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Oct 24 1944. and that I last saw h alive on Oct 23 1944.

Immediate cause of death: Acute Cerebral Dilitation | Duration: 6 weeks
Due to: Cardio-vascular disease | 1
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Henry Glassman M. D.
Address 703 W. Lafayette St Date signed Oct 24 44

G21905

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45

G21905 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 673 N. Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgia Bright

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Thomas Bright | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1912

8. AGE: Years 32 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER 12. Name Irvin
13. Birthplace Virginia

MOTHER 14. Maiden Name ?
15. Birthplace Virginia

16 (a) Informant Thomas Bright
(b) Address 673 Franklin St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Portsmouth Va.

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

19 (a) OCT 24 1944 (Date received) (b) Hunter H. Williams M.D. (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1944, at 3.00 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McNally M.D. (Medical Examiner.)
Date signed 10/23/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Fill in all items. Be sure the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21906 — Hughes — G21906

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

File No. 85971 — Registered No. 106 C (over)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 10 — 26-6
(e) Length of stay in Baltimore (yrs., mos., or days) 1 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6204 Shipview Way. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME George Hughes (HUGHES)

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. ? 1868 ?

8. AGE: Years 76 | Months 8 | Days ? | If less than one day hr. min.

9. Birthplace Washington, D. C. (Town, county, and state)

10. Usual Occupation Water Tender

11. Industry or business U. S. Steel Corp.

FATHER
12. Name James Hughes
13. Birthplace ?

MOTHER
14. Maiden Name Liza Rogan
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory St. John's
Location Connellsville, Penna.

18 (a) Funeral director Lilly & Zeiler Co.
(b) Address 403 S. Wolfe St.

19 OCT 24 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1944 at 11 34 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7/13 1944 to 10/23 1944 and that I last saw h[illegible] alive on 10/23 1944.

Immediate cause of death — Duration

Bronchitis ; emphysema

Due to

Due to

Other Conditions Generalized arteriosclerosis.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Emphysema. Bronchitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Elizabeth Woodward M. D.
Address Baltimore City Hospitals Date signed 10-24-44

G21907 BARNO ✓ G21907

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 112

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Poplar Grove St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Stephen M. Barno

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 1922

8. AGE: Years	Months	Days	If less than one day
22	6		hr. min.

9. Birthplace Portage Penna.
(Town, county, and state)
10. Usual Occupation Aircraft Mechanic
11. Industry or business Glenn L. Martin

FATHER
12. Name Andrew C. Barno
13. Birthplace Pa.

MOTHER
14. Maiden Name Helen Portash
15. Birthplace Pa.

16 (a) Informant Mr. Andrew Barno, Jr.
(b) Address 1009 Sorrow Av Portage Pa

17 (a) Removal (b) Date thereof 10/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Portage Pa.

18 (a) Funeral director F. B. Tapparts & Sons
(b) Address 1300 Eutaw Place

19 OCT 25 1944 Huntington Williams, M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1944, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 1st 1943 to Oct. 24 1944, and that I last saw h im alive on Oct. 24 1944.

Immediate cause of death	Duration
Status Pneumonicus	acute
Due to Bronchial Pneumonia	4 yrs.
Due to	
Other Conditions Hypertension	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Reese, M.D.
Address 2314 West North Ave. Date signed 10/25/44

VS 150

G21908

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13B

G21908 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 905 W. Fayette St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 905 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Louis Dandridge
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race Col
6 (a) Single, married, widowed, or divorced. M
6 (b) Name of husband or wife Annie Dandridge
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb. 22 1909
8. AGE: Years 35 Months 8 Days - If less than one day hr. min.
9. Birthplace Center Cross - Essex Co - Va (Town, county, and state)
10. Usual Occupation
11. Industry or business
12. Name of FATHER George Dandridge
13. Birthplace Center Cross Va
14. Maiden Name of MOTHER Annie F Lattaker
15. Birthplace Center Cross - Va
16 (a) Informant Mrs. Annie Dandridge
(b) Address 905 W. Fayette St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-44 (month) (day) (year)
(c) Cemetery or crematory Center Cross
Location VA - Essex Co.
18 (a) Funeral director Mrs Peter R Williams
(b) Address 322 N Schroeder St
19 OCT 25 1944 (Date rec'd by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1944, at 1:00 M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1944 to 10/24 1944 and that I last saw h[illegible] alive on 10/22 1944
Immediate cause of death Pulmonary Pneumonia

Duration

Due to
Due to TO
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Evan A Bilkes
Address 600 N Caldwell St Date signed 10/25/44

G21909

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

820

G21909 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1802 Penna Ave.
(c) Hospital or institution: 16

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 1131 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: John Clinton Downs

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-16-6761

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: *Widower

6 (b) Name of husband or wife: Etta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 3/29/1885

8. AGE: Years 58 | Months 6 | Days 25 | If less than one day hr. min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual Occupation: Messenger

11. Industry or business

FATHER 12. Name: Horace Downs

FATHER 13. Birthplace: Balto. Md.

MOTHER 14. Maiden Name: Margaret Wells

MOTHER 15. Birthplace: Balto. Md.

16 (a) Informant: Nimrod Downs

(b) Address: 614 George St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)

(c) Cemetery or crematory: Mt. Auburn

Location: Md.

18 (a) Funeral director: George G. Kelson

(b) Address: 1303 Presstman St.

19 (a) OCT 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/23 1944, at 8:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1 1944, to 10/23 1944, and that I last saw h. alive on 10/23 1944

Immediate cause of death: Cerebral Apoplexy — Duration: Instant

Due to:

Due to: Hypertension

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Carson C. Johnson M. D.

Address: 1802 Penna Ave Date signed 10/24/44

JL - G21910

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

130

G21910 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland.
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 hr; 10m.
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1801 W. Lanvale St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alice Miller

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Milton J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 29, 1876

8. AGE: Years	Months	Days	If less than one day
67	10	24	hr. min.

9. Birthplace Penna
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Lane
13. Birthplace England

MOTHER
14. Maiden Name Sophia Watson
15. Birthplace Penna.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.,

17 (a) Cremd (b) Date thereof 10/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Fallon Funeral Dir
(b) Address 1219 E Fayette St

19 (a) (b)
(Signature of Registrar)

OCT 25 1944 Huntington Williams, M.D. Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23 1944, at 12:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1944 to Oct 23 1944, and that I last saw h. alive on Oct 21 1944.

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary Tuberculosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Luis Dalmau
Address Baltimore City Hospitals Date signed 10/25/44 M. D.

LUIS DALMAU, M.D.

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21911

CERTIFICATE OF DEATH

47 G21911

Registered No.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Hanover St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 35 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Robert Paul Davis

If U. S. Veteran specify WAR ...

(a) Residence: No. 1623 Hanover St., ... Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a. If married, widowed, or divorced: HUSBAND of (or) WIFE of Martha

6. DATE OF BIRTH (month, day, year) Dec 19 1875

7. AGE Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
68	10	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Inspector

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. B & O R R

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Pa

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Martha L. Davis
(Address) 1623 Hanover St

18. BURIAL, CREMATION, OR REMOVAL
Place Glen Haven Date 10/27 1944

19. UNDERTAKER Fallon Bob Lee
(Address) 1217 S. Paca St

20. FILED OCT 25 1944 19... Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct 24, 1944

22. I HEREBY CERTIFY, That I attended deceased from June 19 44 to Oct 24 19 44
that saw h... alive on Oct 23, 19 44 Death is said to have occurred on the date stated above, at 1 3/4 m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Carcinoma of stomach	6 Mos

Other contributory causes of importance:

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? X-ray Was there an autopsy? No

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? ... Date of injury ... 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?
If so, specify ...

(Signed) Isaac Miller M. D.

(Address) 1111 Cathedral St

Information should be carefully supplied. Age must be given in all cases, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Huntington Williams, M.D.

G21912

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G21912

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 703 E. 20th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 703 E. 20th Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOSEPH W. GOODING

3 (b) If veteran, name war: No
3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Margaret
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 24, 1887

8. AGE: Years	Months	Days	If less than one day
56	11	29	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business Food Fair

FATHER
12. Name Henry C. Gooding
13. Birthplace Maryland

MOTHER
14. Maiden Name Ella Abey
15. Birthplace Maryland

16 (a) Informant Dorothy M. Gooding
(b) Address 703 E. 20th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26, 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) OCT 25 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1944, at 9:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from July 13, 1943, to Oct. 23 1944, and that I last saw h[illegible] alive on Oct 23 1944.

Immediate cause of death Coronary Thrombosis
Due to Chronic Myocarditis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 1 day

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurence J. McGee M.D.
Address 1331 E. Northern Date signed 10-24-44

G21913

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G21913

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Do not abbreviate. Write out full the name of street, city, or town, and county. Do not use ditto marks. Be sure to answer each question. If unknown or if the question is not applicable, write "unknown" or "not applicable," as the case may be. Do not write in the space below. Physicians: please write the causes of death clearly and legibly. Make return within 24 hours to Registrar of district in which death occurred. Do not bury or remove body without a permit. Do not fail to state correct age in every case. Please write in ink. Do not use pencil. Be sure to sign certificate.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greenspring & Belvedere
(c) Hospital or institution: Levindale Home
(d) Length of stay in hospital or inst. (yrs., ~~mos., or days~~) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1916 Ruxton ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MOLLIE LONDON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife Late Nathan
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years	Months	Days	If less than one day
80			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business None

FATHER
12. Name Jacob Coppersmith
13. Birthplace Russia

MOTHER
14. Maiden Name Thelma ?
15. Birthplace Russia

16 (a) Informant Isaac London
(b) Address 1916 Ruxton Ave

17 (a) Burial (b) Date thereof Oct 25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson Bros
(b) Address 1124-26 W. North ave
(By whom) (Date rec'd by registrar) Huntington Williams, M.D.

VS 156

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1944, at 4 p M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1941, to October 24 1944, and that I last saw h. alive on October 24 1944

Immediate cause of death Bronchopneumonia, bilateralis

Due to Cardiovascular disease

Due to

Other Conditions Myocarditis chronica
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Henry Nagel for Dr. Goldstein M. D.
Address Levindale Home Date signed Oct. 27, 1944

G21914

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30 D

Registered No. G21914

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave 1540
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3919 Boarman Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Solomon Shulman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dena
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1876
8. AGE: Years 68 | Months | Days | If less than one day hr. min.
9. Birthplace Russia (Town, county, and state)
10. Usual Occupation
11. Industry or business Carpenter

FATHER
12. Name Harry Shulman
13. Birthplace Russia

MOTHER
14. Maiden Name Etta Bernstein
15. Birthplace 3813 Ridgewood Ave Russia

16 (a) Informant Mrs Reba Schlesinger
(b) Address 3813 Ridgewood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 25 1944 (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave
18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave
19 (a) 10 25 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23 1944, at 8:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 10/13 1944 to 10/23 1944 and that I last saw h[im] alive on 10/23 1944
Immediate cause of death CARDIAC FAILURE — Duration 11 days
Due to Arteriosclerotic H. D.
Due to Myocardial Infarction
Other Conditions Pneumonia
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac Simon M.D.
Address Sinai Hospital Date signed 10/23/44

G21915

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G21915 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3241 Shannon Drive
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3241 Shannon Drive
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Emilie Fickenscher FICKENSCHER

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Michael Fickenscher
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Nov. 25, 1871

8. AGE: Years 72 | Months 10 | Days 28 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name ? Fuchs FISHER
13. Birthplace Germany

MOTHER
14. Maiden Name unknown
15. Birthplace Germany

16 (a) Informant Michael Fickenscher
(b) Address 3241 Shannon Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto Co Md

18 (a) Funeral director Ulman Funeral Home
(b) Address 2008 Orleans St

19 (a) ... (Date rec'd by registrar) (b) ... Registrar

OCT 25 1944 Huntington Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23. 1944; at 12 30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1944, to Oct 23 1944, and that I last saw her alive on Oct 24 1944.

	Duration
Immediate cause of death: Cerebral Hemorrhage	2 d.
Due to Hypertension	2 d.
arteriosclerosis	2 d.
Due to C.Ca. Interstitial Nephritis	2 d.
Other Conditions Diabetes Mellitus.	3 yr.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I Fa Stevens M. D.
Address 2878 Harford Rd Date signed 10-24-44

G21916

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

G21916
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 734 Bartlet Avenue
(c) Hospital or institution: 9 8

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 734 Bartlet Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William A.Fisher

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lida A.Williams
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) March 20,1877

8. AGE: Years 67 | Months 7 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore,Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business Unemployed

FATHER
12. Name John M.Fisher
13. Birthplace Baltimore,Md.

MOTHER
14. Maiden Name Margaret M.Coluburn
15. Birthplace Baltimore,Md.

16 (a) Informant Mrs.Lida A.Fisher (Wife)
(b) Address 734 Bartlet Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct.26,1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director George J.Ruth,Inc.
(b) Address 1735 Harford Avenue

19 (a) OCT 2 [illegible] Huntington Ridge
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1944, at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 1944, and that I last saw h— alive on Oct 2 1944.

Immediate cause of death	Duration
Cardiac Insufficiency	?
Due to Arteriosclerosis	?
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Laurel Low M. D.
Address 861 E Mtn Ave Date signed 10/27/44

G21917

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

Registered No. G21917

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sinai Hosp. Balto. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 mos
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 218 E. Barney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME August Dehn

3 (b) If veteran, name war: —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	

6 (b) Name of husband or wife Mary E. Dehn
6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) May 28 1873

8. AGE: Years	Months	Days	If less than one day
71	4	25	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William Dehn
13. Birthplace ?

MOTHER
14. Maiden Name ? Glyser
15. Birthplace Germany

16 (a) Informant Mrs Mary E. Dehn
(b) Address 218 E. Barney St.

17 (a) Burial (b) Date thereof 10/25/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Frederick Ave.

18 (a) Funeral director John F. Denny Inc.,
(b) Address 715 Light St.

OCT (a) 25 1944 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23- 1944, at 7.58 P.M

21. I certify that I took charge of the remains described above, held an Inspection-Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shock

Due to

Other Conditions 3rd degree burns, 75% surface

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 24/4
(a) Date of injury 10-23- at 3.20 P.M.
(b) Where did injury occur? 218 E. Barney St
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Smoking cigarette, clothes caught fire

23. Signature Howard J. Wheeler M.D.
Medical Examiner.
Date signed 10-24-44

Please write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G21918

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21918

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33 E Calvert St
(c) Hospital or institution: Union Mem'l Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 W University Pky
(If rural give location)
(e) Citizen of foreign country? — No — (Yes or No)
If yes, name country —

3 (a) FULL NAME Bertha Lee Williams

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband or wife: John Hamilton C. Williams
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): July-9-1866

8. AGE: Years 78 | Months 3 | Days 14 | If less than one day ____ hr. ____ min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual Occupation: none
11. Industry or business —

FATHER
12. Name: Charles H. Wright
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Susan V. Slizer
15. Birthplace: Maryland

16 (a) Informant: Henry H. Williams (Son)
(b) Address: 120 E. 175 St. N.Y. City

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-44 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Baltimore

18 (a) Funeral director: Sherwood Memorials
(b) Address: 18 W Mulberry

19 (a) OCT 25 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23- 1944, at 6 P. M.

21. I certify that I took charge of the remains described above, held an autopsy, inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fractured Skull

Due to:

Other Conditions: Cerebral laceration
Lacerations of both knees
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-20- at 12/1 9.30 P. M.
(b) Where did injury occur? Canterbury Rd & Un. P'kway
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by street car

23. Signature: Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-24-44

PLEASE WRITE PLAINLY, with unfading ink. Be sure to state the causes of death clearly and legibly. Do not use abbreviations or symbols. Be sure the correct age is especially important. Physicians: please write the

G21919

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X ✓ 169

G21919 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Lutherville
(If outside city or town limits, write RURAL and give town)
(d) Street No. York Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country No

3 (a) FULL NAME Leonard Snelson Leonard Gordon Snelson

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-22-4600

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Persis Lee Snelson

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1908

8. AGE: Years 36 | Months 2 | Days 6 | If less than one day — hr. — min.

9. Birthplace Louisa County, Virginia
(Town, county, and state)

10. Usual Occupation Fireman

11. Industry or business Penn. R.R.

FATHER
12. Name John W. Snelson
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary B. Smith
15. Birthplace Virginia

16 (a) Informant Mrs. Persis Lee Snelson
(b) Address Timonium, Maryland.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Oct. 25, 1944 (month) (day) (year)

(c) Cemetery or crematory J. C. Flynn Funeral Home
Location Beaver Dam, Hanover Co, Va.

18 (a) Funeral director John Burns' Sons
(b) Address Towson, Md.

19 OCT 25 1944 (Registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1944, at 2:40 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:

(a) Date of injury 10-20- at 12/5 4A M.
(b) Where did injury occur? Union Station Penna. R.R. Station
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? Yes
(d) Means of injury Fell from engine cab

23. Signature Howard J. Weesner M.D.
Medical Examiner.
Date signed 10-24-44

Please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians: please write the causes of death clearly and legibly. Physicians:

G21920

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G21920

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) doa
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Barnes street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charlotte Collins Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: f

5. Color or race: c.

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Percy Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years: 56 | Months | Days | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name: Charles Collins
13. Birthplace: Md.

MOTHER
14. Maiden Name: Janie Cornish
15. Birthplace: Md.

16 (a) Informant: Leonard Cornish
(b) Address: 1716 Barnes St.

17 (a) Burial (Burial, cremation or removal) (b) Date thereof: Oct 25, 1944 (month) (day) (year)
(c) Cemetery or crematory: Mt Calvary
Location

18 (a) Funeral director: Mrs Kate R. Williams
(b) Address: 322 N Schroeder St.

19 (a) OCT 25 1944 (Registrar's signature) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 22 1944, at M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Acute Pulmonary Edema

Due to

Other Conditions: Chronic Myocardial degeneration

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Howard J. Weaver M.D.
Medical Examiner.
Date signed: 10/23/44

PLEASE WRITE PLAINLY; WITH INDELIBLE INK. Be sure the causes of death clearly and legibly. Give the correct age is especially important. Physicians: please write the

G21921

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

✓ G21921
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be sure that the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2418 Loch Raven Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 Loch Raven Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HENRY GRAF

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband of wife Julia C. Graf
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 4, 1887

8. AGE: Years	Months	Days	If less than one day
57	1	19	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Fireman
11. Industry or business Balto. City. Fire Dept.

FATHER
12. Name Herman Graf
13. Birthplace A. A. Co., Md.

MOTHER
14. Maiden Name Anna Greifzu
15. Birthplace Phila., Pa.

16 (a) Informant Miss Dorothy Graf, daughter
(b) Address 2418 Loch Raven Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Registered by registrar) (b) Huntingtown, Md. Oct 25 1944

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 22, 1944 to Oct. 23, 1944 and that I last saw him alive on Oct. 23, 1944.

Immediate cause of death	Duration
Coronary occlusion.	Immediate
Due to Coronary Sclerosis - atheroma	?
Due to	
Other Conditions Hypertension.	?

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:
of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank H. Ogden. M. D.
2701 N. Calvert - Date signed Oct. 24, 44

G21922 | BALTIMORE CITY HEALTH DEPARTMENT | G21922 Registered No.

CERTIFICATE OF DEATH

186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 34 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 636 E. 35th st (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs Mary Elizabeth Shaul

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F.	W.	Widowed

6 (b) Name of husband or wife: John T. Shaul
6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug 11, 1871

8. AGE: Years	Months	Days	If less than one day
73	2	12	____ hr. ____ min.

9. Birthplace: Maryland (Balto. Co.) (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: John Lyons
13. Birthplace: Ireland

MOTHER
14. Maiden Name: ?
15. Birthplace: ?

16 (a) Informant: Mrs. Eugene E. Sullivan
(b) Address: 636 E. 35th St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge Cem.
Location: Pikesville, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by Registrar) OCT 25 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10-23 1944 at 9 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-20 1944 to 10-23 1944, and that I last saw her alive on 10-23 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Pneumonia	2 days.
Due to Fractured rt. hip	34 days.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 9-25-44
Major findings of operation: Application of Anderson wall leg Counter Traction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 9/3
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 9-20-44 at 6 P M
(c) Where did injury occur? Baltimore (City or town) Md. (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? ____
(e) Means of injury: Fall on floor

23. Signature: Glenn O. Brewer
Attending Physician or Medical Examiner, signed 10/25/44
Homer J. Mullis, M.D.

VS 150

G21923

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30C

Registered No. G21923

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green + Lombard
(c) Hospital or institution: Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 25
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 716 Dallis St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carlton Douglass

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years	Months	Days	If less than one day
31			hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation laborer

11. Industry or business Bulkhead shipyard

FATHER
12. Name Samuel
13. Birthplace Md

MOTHER
14. Maiden Name Cora Sutton
15. Birthplace Md

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 21 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 25 1944 (Date rec'd by registrar) (b) Howington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/19/44 1944 at 4:15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 5 1944 to Oct 17 1944 and that I last saw h[redacted] alive on 10-17 1944.

Immediate cause of death sub-arachnoid hemorrhage

Due to [redacted]

Due to Paresis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E. Hug M. D.
Address Date signed 10-21-44

2256

G21924

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1640

G21924

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 805 E. 22nd Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 805 E. 22nd Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Walter Johnson

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892.

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Thomas Johnson
13. Birthplace Balto

MOTHER 14. Maiden Name Ella Johnson
15. Birthplace Baltimore

16 (a) Informant Mrs. Street 805 E. 22nd St
(b) Address

17 (a) Burial (b) Date thereof 10-27-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary M Medfield
(b) Address 41 E. 22nd St.

19 (a) OCT 25 1944 (b) Huntington Williams M.D.
Registrar

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Be sure the causes of death clearly and legibly. correct age is especially important. Physicians: please write the

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24- 1944, at 10 45 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Live death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Hanging

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-24- at A M.
(b) Where did injury occur? Cellar a basement room
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Suspended with rope-tie

23. Signature Howard J. Anderson M.D.
Medical Examiner.
Date signed 10-24-44

G21925 CREAGH G21925

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2437 Barclay St. City 18
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN MATTHEW CREAGH

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 11, 1863
8. AGE: Years 81 Months 9 Days 13 If less than one day hr. min.
9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Peter Creagh
13. Birthplace Ireland

MOTHER
14. Maiden Name Honora O'Donnell
15. Birthplace Ireland

16 (a) Informant Miss Mary Creagh
(b) Address CH-4628 Baltimore

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10 26 1944 (month) (day) (year)
(c) Cemetery or crematory Catholic Cemetery
Location

18 (a) Funeral director Mary W Wakefield
(b) Address 50 E 22nd St

19 (a) Oct 27 1944 (Date) (Registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1944, at 1:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1944, to October 24 1944, and that I last saw him alive on October 23 1944.

	Duration
Immediate cause of death Cardio-respiratory failure	
Due to Cerebro-vascular accident	
Due to Arteriosclerotic heart disease	2 1
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. Lee Thompson Jr. M. D.
Address 332 E. University Pkwy Date signed 10/26/44

G21926

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G21926

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please correct age in especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3513 Newland Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3513 Newland Rd 3513 (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elenor Lappe.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/1/1868

8. AGE: Years	Months	Days	If less than one day
75	11	23	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

MOTHER / FATHER

12. Name John Lappe

13. Birthplace Md.

14. Maiden Name Margaret L. P.

15. Birthplace Md

16 (a) Informant Mrs. B. J. Seymour

(b) Address 3513 Newland Rd

17 (a) Burial (b) Date thereof 10/26/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location

18 (a) Funeral director B. J. Tabler & Sons

(b) Address 1308 Light St.

OCT 25 1944 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24/1944, at 1140 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/11 1944 to 10/24 1944, and that I last saw h alive on Oct 12 1944.

Immediate cause of death	Duration
Myocardial Insufficiency	4 days
Due to Metastatic Carcinoma.	
Due to Generalized Arteriosclerosis	10 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation?

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Walsh M. D.

Address 532-622 St Date signed 10/25/44

G21927

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

G21927 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Homeland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 415 Homeland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sarah Ann Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Michael Brown | 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 4/30/1854

8. AGE: Years 90 | Months 6½ | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county and state)

10. Usual Occupation Home Wife

11. Industry or business —

FATHER 12. Name James Mullen
13. Birthplace Ireland

MOTHER 14. Maiden Name Ann Caird
15. Birthplace Ireland

16 (a) Informant Mr. James Brown
(b) Address 415 Homeland.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Moriah Cemetery
Location Lutz

18 (a) Funeral director J. J. Pohlhaus & Sons
(b) Address Light St.

18 (c) OCT 25 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1944, at 4:25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1941 to Oct 24 1944, and that I last saw him alive on Oct 23 1944

Immediate cause of death Senility — Duration 2 yrs.

Due to General Degeneration — Duration 10 yrs.

Due to Chronic Arthritis — Duration 20 yrs.

Due to Enlarged Prostate

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herbert M. Foth M. D.
Address 824 St. Paul St Date signed Oct. 24-44

G21928

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21928 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 414 Orchard st
(c) Hospital or institution:
11
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 22 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 414 Orchard st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A Edwards.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	Col	Married

6 (b) Name of husband or wife John H.
6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) 5-1-1878

8. AGE: Years	Months	Days	If less than one day
66	5	21	hr. min.

9. Birthplace N. Carolina (Town, county, and state)
10. Usual Occupation Saundress
11. Industry or business

FATHER
12. Name Charles Smith
13. Birthplace N. C.

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant John H Edwards
(b) Address 414 Orchard st
17 (a) Burial (b) Date thereof 10-26-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem
Location Balto County Md
18 (a) Funeral director William A Jackson
(b) Address 916 Penna ave
19 (a) (Date rec'd by registrar) (b) Registrar

OCT 25 1944 Huntington for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 22 1944, at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19

Immediate cause of death Cerebral Hemorrhage

Due to

Due to

Other Conditions Hemiplegia

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H Edwards M. D.
Address 604 Edgewater Dr Date signed 10-25-44

G21929

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G21929 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 926 Bennett Place (If rural give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3 (a) FULL NAME Ronnie Lamontie

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Wilson

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 9-8-1912

8. AGE: Years 32 | Months 1 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Welder

11. Industry or business

FATHER 12. Name James Lamontie
13. Birthplace N. C.

MOTHER 14. Maiden Name Mary Riggins
15. Birthplace N. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 26/44 (month) (day) (year)
(c) Cemetery or crematory Fayetteville
Location North Carolina

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St

19 (a) OCT 25 1944 Registrar
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-23 1944, at 12.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct-23 1944 to Oct-23 1944, and that I last saw him alive on Oct-23 1944.

Immediate cause of death: Lobar pneumonia LLL + RLL — Duration: 4 days

Due to.....

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation:.....

of autopsy: Lobar pneumonia LLL & LUL

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Albert A. Kattus M. D.
Address Johns Hopkins Hosp Date signed 10/25/44

G21930

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

Registered No. G21930

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1518 Covington Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1518 Covington Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARGARET L. SEVERN

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife: Frank Severn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): June 29, 1890

8. AGE: Years	Months	Days	If less than one day
54	3	25	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: Home

FATHER
12. Name: Paul Appel
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Anna Holthouse
15. Birthplace: Maryland

16 (a) Informant: Family
(b) Address: 1518 Covington Street

17 (a) B (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory: Holy Redeemer
Location: Belair Road

18 (a) Funeral director: James L. McCauley
(b) Address: 130 E. Fort Avenue

19 (a) Filed OCT 25 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1944 at 4.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 14 1944 to Oct 24 1944, and that I last saw h[er] alive on Oct 21 1944.

Immediate cause of death	Duration
Myocarditis	
Acute Decompensation	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. H. Barranco M. D.
Address 436 E Fort Date signed 10/25/44

JL - 90052 G21931

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30D

G21931 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct; age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1312 Parrish St. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Richard Simms

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 6, 1900

8. AGE: Years	Months	Days	If less than one day
44	9	17	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

MOTHER / FATHER	
12. Name	John Simms
13. Birthplace	Md.
14. Maiden Name	Hester ?
15. Birthplace	Md.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Geo. M. Kelson

(b) Address 1363 Presstman St.

19 (a) OCT 25 1944 (b) Huntington Williams, M.D. Registrar

(Date rec'd by registrar)

VS 130

MEDICAL CERTIFICATION P

20. DATE OF DEATH October 23, 1944, at 11:45M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1944, to Oct. 23, 1944, and that I last saw him alive on Oct. 23, 1944.

Immediate cause of death	Duration
Uremia	One week
Congestive heart failure	?
Due to Hypertensive Cardiovascular disease	?
Due to	
Other Conditions Partial Hemiplegia old	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy no autopsy? Institutional

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H M Phillips M. D.

Address Balt. City, Md. Date signed 10-25-44

21932

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G21932 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: So Balto. Gen. Hosp

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2499 Tamman
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Scotland

3 (a) **FULL NAME** Weapon Cumming Jardine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race Wh | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day 36 hr. min.

9. Birthplace So. Balto Gen Hosp.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER 12. Name Joseph Snyder
13. Birthplace W. Va

MOTHER 14. Maiden Name Ruby Gonder
15. Birthplace W. Va

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 25 1944 (Date rec'd by registrar) (Signature of registrar) Harry V. Williams M.D.

VS 184

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22/1944 at 8 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h alive on 19.

Immediate cause of death	Duration
(a) atelectasis	
Due to (b) Prematurity	
Due to (c)	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leslie B. MacDonald M.D.
Address 23 Regent St Date signed Oct 25 1944

2261

G21933

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

G21933
Registered No.

TN. 89353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1 4
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1011 Watson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Paul Ramsey

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	C	Widower

6 (b) Name of husband or wife Pearl (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July ? ? 1892

8. AGE: Years	Months	Days	If less than one day
? 52	? 3	?	hr. min.

9. Birthplace Virginia
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Oscar Ramsey (D
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Powers (D
15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 25 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 14, 1944 19 6.00 P.M. at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 14 1944, and that I last saw h[illegible] alive on Oct 14 1944.

Immediate cause of death: Heart failure — Duration: 6 mos.
Due to: Pulmonary Tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M. D.
Address Balto City Hosp Date signed 10/27/44

2260

G21934

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

JO #68968

Registered No. G21934

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 mos. 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 315 Preston St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Coleman

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 7, 1891

8. AGE: Years	Months	Days	If less than one day
53	-7-	-9-	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Isaac Coleman (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Patsy Wright (d)
15. Birthplace Virginia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 25 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 25 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 16, 1944, at 10:35 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 13, 1944, to Oct. 16, 1944, and that I last saw him alive on Oct. 16, 1944.

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary Tuberculosis (bilateral)	3 years
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold Fillon M. D.
Address Balto. City Hosp. Date signed 10/25/44

VS 180

2259

G21935

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G21935 Registered No.

Please write plainly, with unfading ink. Every question must be answered, or the certificate will be returned for correction. Usage is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2-0-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 515 N. Bethel Alma
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Woods

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10, 1897

8. AGE: Years 47 | Months 4 | Days 14 | If less than one day hr. min.

9. Birthplace Woodbury Va.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Elsie Wilmore
(b) Address 822 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy A. Nelson
(b) 1000 Bl Pennsylvania Ave

19 (a) OCT 25 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24-44 1944, at 9:05 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Arteriosclerotic Cardio-Vascular Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ causes of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-24-44

G21936 G21936

#61818

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 137a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 S. Caroline St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Johan Jackson

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Negro	Widower

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-12-67

8. AGE: Years	Months	Days	If less than one day
76	10	11	hr. min.

9. Birthplace Md. - (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Ifwin Jackson -
13. Birthplace N. C.

MOTHER
14. Maiden Name Caroline Hayward
15. Birthplace Md. -

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Druid Park Ave

25 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 23, 1944 at 4:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 3 1944 to Oct 23 1944 and that I last saw h[illegible] alive on Oct. 23 1944

Immediate cause of death	Duration
coronary occlusion	
Due to generalized arteriosclerosis	at least 1 yr.
Due to	
Other Conditions Benign prostatic hypertrophy	

(Include pregnancy within 3 months of death)
Date of operation 10/11/44 & 10/23/44
Major findings of operation: Benign prostatic hypertrophy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edw. A. Richardson, Jr.
Address Johns Hopk. Hosp. Date signed 10/25/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21937

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21937

Registered No. .....

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address .....
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 McCulloh Street (If rural give location)
(e) Citizen of foreign country Not Colored (Yes or No)
If yes, name country .....

3 (a) FULL NAME William Griffin

3 (b) If veteran, name war .....
3 (c) Social Security Account No. .....

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife .....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
84			..... hr. ..... min.

9. Birthplace Talbott Co. Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business .....

FATHER
12. Name Unknown
13. Birthplace .....

MOTHER
14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant William Johnson
(b) Address 1502 Gleanage
17 (a) Burial (b) Date thereof 10/26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location .....
18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Brantley
19 (a) OCT 25 1944 (b) .....
(Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were
IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease
.....
Due to .....
.....
Other Conditions .....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury ..... at ..... M.
(b) Where did injury occur? .....
(c) Did injury occur at home, on farm, industrial place, in public place? ..... While at work? .....
(d) Means of injury .....

23. Signature Robert Lee Bratton M.D.
Medical Examiner.
Date signed Oct 23 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Entry of the causes of death clearly and legibly. ... age is especially important. Physicians: please write the

G21938

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59B

G21938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1226 Ward St
(c) Hospital or institution: n/

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1226 Ward St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John M. Montag

3 (b) If veteran, name war: None
3 (c) Social Security Account No. none

4. Sex: M. | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: May Montag
6 (c) If give, give age — years

7. Birth date of deceased (mo., day, yr.) Jan 15 1871

8. AGE: Years 73 | Months 9 | Days 7 | If less than one day: hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Valentine Montag
13. Birthplace Baltimore

MOTHER
14. Maiden Name Christiana Kobler
15. Birthplace Baltimore

16 (a) Informant Mrs Ella Lyckes
(b) Address 1226 Ward St

17 (a) Burial (b) Date thereof 10-25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Westview
Location Baltimore

18 (a) Funeral director Frederick & Cole
(b) Address 1200 W. Lombard St

19 (a) (Deputy) Registrar (b) Huntington Williams

OCT 25 1944

vs 100

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 22 1944, at 1.45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1944 to Oct 22 1944 and that I last saw h alive on Oct 21 1944

Immediate cause of death: Car Ray as cerebr
Due to: Arteriosclerosis
Due to: Arterio Sclerosis
Other Conditions: Senility

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration: 2 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walter D Cotton
Address 1029 Edmondson Date signed 10/25/44

G21939 BALTIMORE CITY HEALTH DEPARTMENT G21939

CERTIFICATE OF DEATH

94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louna Norris

3 (b) If veteran, name war	3 (c) Social Security Account No.
W.	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Over 85			hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mrs Wilhelmina A Stewart
(b) Address 205 N Conkling St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/26/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore Md
18 (a) Funeral director Wilson & Foster
(b) Address 1317 N Fulton Ave
19 OCT 26 1944 (b) Huntington Williams M.D.
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1944, at 10 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1944, to Oct. 24 1944, and that I last saw h Sr. alive on Oct. 24 1944

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Advanced Atherosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Louis Jacob M. D.
Address 1700 Eutaw Place Date signed Oct. 25-1944

G21940

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

45B

Registered No. G21940

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1917 HARLEM AVE.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1917 HARLEM AVE
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME HERBERT S. COWLEY

3 (b) If veteran, name war NONE
3 (c) Social Security Account No. 577-20-1607

4. Sex M
5. Color or race W
6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife CLARA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 14, 1870

8. AGE: Years 74 | Months 3 | Days 11 | If less than one day hr. min.

9. Birthplace BALTIMORE, Md.
(Town, county, and state)

10. Usual Occupation COMPOSITOR

11. Industry or business WASH. STAR (RETIRED)

FATHER
12. Name SAMUEL T. COWLEY
13. Birthplace W. VA.

MOTHER
14. Maiden Name ELIZA JANE McCLELLAN
15. Birthplace MARYLAND

16 (a) Informant MRS. CLARA COWLEY
(b) Address 1917 ST. PAUL ST.

17 (a) BURIAL (b) Date thereof 10/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 127 St. Paul St

OCT 26 1944 (b) Huntington Williams, M.D.
(Date received by Registrar) (Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 25 1944 at 7 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to Oct 25 1944, and that I last saw him alive on Oct 25 1944

Immediate cause of death	Duration
Respiratory failure	
Due to Carcinoma of tongue	2 years
Due to	
Other Conditions Hemiplegia-rt	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Isadore Shorfaberg M.D.
Address 601 N. Monroe St. Date signed 10/25/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21941

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G21941

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 620 N. Fremont
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 70yrs

16

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 620 N. Fremont (If rural give location)
(e) Citizen of foreign country? Md. (Yes or No) If yes, name country

3 (a) FULL NAME Charles Walter Hagerty

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-01-8752

4. Sex M

5. Color or race W

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Helen M. Hagerty

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 15th 1874

8. AGE: Years 70 Months Days 9 If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Packer (Retired)

11. Industry or business P. D. & Co.

FATHER — 12. Name James Hagerty
13. Birthplace Maryland

MOTHER — 14. Maiden Name Margaret Miele
15. Birthplace Maryland

16 (a) Informant Mrs. Helen Hagerty
(b) Address 620 N. Fremont St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st

19 (a) Date received OCT 28 1944 (b) Huntington Williamsburg, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 27 1944, to Oct 24 1944, and that I last saw h alive on Oct 24 19 44

Immediate cause of death	Duration
Due to Ca. Myocarditis	1943
Due to Ca. Intestines	1943
Other Conditions Nephritis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James Hagerty

Address 1663 W. Fort Ave. Date signed 10/27/44

G21942 ✓ G21942

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1529 Druid Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1529 Druid Hill Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie M. Francis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Wm. H. Francis
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1863

8. AGE: Years	Months	Days	If less than one day
80	9	23	hr. min.

9. Birthplace Union Co., Penna.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Penna

MOTHER
14. Maiden Name Not Known
15. Birthplace Penna

16 (a) Informant Mrs Rheda Spellar
(b) Address 1529 Druid Hill Ave.

17 (a) Burial (b) Date thereof 10-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Jesse W. Redden
(b) Address 436 W. Biddle St.

19 (a) (b)
(Signature) Registrar

OCT 26 1944 VS file Lillian Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1944, at 12P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10.10.1944 to 10.24.1944, and that I last saw her alive on 10.22.1944.

Immediate cause of death acute pulmonary edema

Due to acute coronary occlusion

Due to hypertension & arteriosclerotic cardio-vascular

Other Conditions renal disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
4 hrs.
12 hrs.
7 yrs.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James P. Carr, M. D.
Address 575 Mosher St. Date signed 10-25-44

G21943

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G21943

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St.
(c) Hospital or institution: St Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2418 Harlem ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Pinkney J. Hamilton

Pinkney J. Hamilton

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	S.

6 (b) Name of husband or wife ✓

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 28, 1877

8. AGE: Years	Months	Days	If less than one day
67	1	1	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Clerk

11. Industry or business B.T.O. R.R.

FATHER
12. Name Columbus L. Hamilton
13. Birthplace Balto, Md.

MOTHER
14. Maiden Name Sarah R. Taylor
15. Birthplace Balto, Md.

16 (a) Informant Evelyn C. Hamilton
(b) Address 2418 Harlem Ave

17 (a) Burial (b) Date thereof Oct 26/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine Cemy
Location Powhatan, Balto. Co. Md.

18 (a) Funeral director John Mitchell Sons
(b) Address 1300 Eutaw Place

19 (Registered) OCT 26 1944 Registrar

VS 159

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-24 1944, at 12:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1944, to 10-24 1944, and that I last saw him alive on 10-24 1944.

Immediate cause of death Respiratory Failure — Duration

Due to Pneumonia — over

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: No

of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M E Robertson M. D.

Address 10-24-44 Date signed

St. Josephs Hospital

G21944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 E

Registered No. G21944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4032 Falls Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 65 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4032 Falls Road (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ida May Gibbons

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ernest F. Gibbons
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): Jan. 12. 1875
8. AGE: Years 69 Months 9 Days 11 If less than one day hr. min.
9. Birthplace: Newark Ohio (City, county, and state)
10. Usual Occupation: At Home
11. Industry or business:

FATHER
12. Name: Edward C. Rye
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Sarah C. Bortel
15. Birthplace: Maryland

16 (a) Informant: Ernest F. Gibbons
(b) Address: 4032 Falls Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 26-1944 (month) (day) (year)
(c) Cemetery or crematory: Mt. Olive
Location: Randallstown Maryland

18 (a) Funeral director: Burgee Funeral Home
(b) Address: 3631 Falls Road

19 (a) OCT 26 1944 (Date received by Registrar) (b) Registrar: Williams

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 23. 1944, at 10:55 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 17 1944, to Oct 22 1944, and that I last saw her alive on Oct 22 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Coronary artery disease	?
Due to: Hypertension	?
Other Conditions: None	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:
23. Signature: E E Nichols M. D.
Address: Pikesville 8 Md. Date signed Oct 24 44

VS 150

G21945 ✓ G21945

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3336 Old York Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 78

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3336 Old York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura Augusta Drury

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Robert Drury
6 (c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) June 5. 1866

8. AGE: Years 78 | Months 4 | Days 1/2 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John F. Reinecker
13. Birthplace Baltimore Md

MOTHER 14. Maiden Name Laura Augusta Grove
15. Birthplace Md

16 (a) Informant Mrs Walter Lowry
(b) Address 3306 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Catonsville Md

18 (a) Funeral director Bettger & Lotz
(b) Address 1320 N Charles St

19 OCT 26 1944 (b) (Date filed by registrar) Huntington Williams Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 - 1944, at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 2 1944, to Oct 24 1944, and that I last saw h-er alive on Oct 24 1944.

Immediate cause of death Cancer Liver — Duration 6 months

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature H. Stuckeber Jr M.D.
Address 632 Gouchen Date signed Oct 25 1944

G21946

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G21946

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Linwood ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 w
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Linwood ave
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Clarence W. Graham

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4 Sex Male

5 Color or race White

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Celia.

6 (c) If alive, age years

7. Birth date of deceased (mo., day, yr.) Feb. 20-1874

8. AGE: Years 70 Months 1 Days 4 If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Carpet Business

11. Industry or business Shingle

FATHER 12. Name John Graham

13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Dont Know

15. Birthplace "

16 (a) Informant Celia Graham

(b) Address 11 S. Linwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27-44 (month) (day) (year)

(c) Cemetery or crematory Greenmount

Location West Greenmount

18 (a) Funeral director John E. McGan

(b) Address 300 E. Balto. St.

19 (a) (Date received by Registrar) OCT 20 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1. 44 to Oct 24 44 and that I last saw h[illegible] alive on Oct 24 44

Immediate cause of death Carpet Handpainter Cheiro Sclerosis, Myocarditis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Ross Smiley M.D.

Address 2536 E. Balto Date signed 10-25-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

VS 189

G21947 HUPFER

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G21947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monroe & Caroline Sts.
(c) Hospital or institution:
St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 73 days
(e) Length of stay in Baltimore (yrs., mos., or days) 77 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 154 N. Milton Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. John Hupfer

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Regina Hupfer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1-1867

8. AGE: Years	Months	Days	If less than one day: hr.	min.
77	23	25		

9. Birthplace Balto.
10. Usual Occupation Mattress Cutter
11. Industry or business Upholstery

FATHER
12. Name John Hupfer
13. Birthplace Don't Know

MOTHER
14. Maiden Name Don't Know
15. Birthplace " "

16 (a) Informant Henry Hupfer
(b) Address 503 N. Wilkens Ave

17 (a) Burial (b) Date thereof 10-25-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beloit Rd.

18 (a) Funeral director John E. Mc Gan
(b) Address 300 E. Baltimore St.

19 (a) (b)
(Date received) (Registrar)

VS 150 OCT 26 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25- 1944 at 6:55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-12-44 19 to 10-25-44 19, and that I last saw him alive on 10-25- 1944

Immediate cause of death	Duration
Cardio-Respiratory Failure	—
Due to Generalizing Carcinoma & Terminal Cachexia	2½ yrs.
Due to	—
Other Conditions Recto-Vaginal Fistula - Sepsis	over

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robt. D. McFadden M. D.
St. Joseph's Hosp. Date signed 10-26-44

G21948

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G21948 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1305 E. Biddle
(c) Hospital or institution: X X
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and name town)
(d) Street No. 737 W. Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No) Yes
If yes, name country

3 (a) FULL NAME Annie Mae Sanders

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1913

8. AGE: Years 31 | Months | Days | If less than one day hr. min.

9. Birthplace Hyde Co. N. C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name William Sanders
13. Birthplace Hyde Co, N.C.

MOTHER 14. Maiden Name Indiana Shaw
15. Birthplace Hyde Co. N.C.

16 (a) Informant Mrs. Thomas Sanders
(b) Address 1306 E. Biddle St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-26-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion
Location Sandy Spring, Md.

18 (a) Funeral director Wm. Peter R. W. Blake
(b) Address 327 N. Calhoun St

19 (a) OCT 26 1944 (Date received by Local Registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-23-44 19 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21-44 to 10/23-44. and that I last saw [illegible] alive on 10/23/1944

Immediate cause of death: Lobar Pneumonia — Duration 4 days
Due to Acute Bronchitis
Due to Exposure
Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. R. Blake M. D.
Address 1327 N. Central Date signed 10/27/44

VS 190

G21949

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46M

G21949 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 73 E. Hoffman St.
(c) Hospital or institution: 23
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 73 E. Hoffman St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Mary Myers

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M 67	W	Married

6 (b) Name of husband or wife Helen Marie FKA

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2/7/1878

8. AGE: Years	Months	Days	If less than one day: hr.	min.
66	8	20	17	

9. Birthplace Pittsburg Pa
(Town, county, and state)

10. Usual Occupation Produce dealer

11. Industry or business Self employed

MOTHER / FATHER

12. Name Siegfried Myers

13. Birthplace Germany

14. Maiden Name Johanna Speddel

15. Birthplace Ohio

16 (a) Informant Helen Myers

(b) Address 73 E. Hoffman St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Pulaski Highway

18 (a) Funeral director Wm. J. Lighty Sons

(b) Address 3 W. Light St.

19 (a) OCT 26 1944 (b) Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1944, at 8:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Jan. 15, 1943, to Oct. 27, 1944, and that I last saw him alive on Oct. 27, 1944.

Immediate cause of death	Duration
Acute Dilatation of Heart	
Due to Carcinoma of G.I. tract?	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. P. Friedman, M.D.

Address 1319 Light St. Date signed 10/28/44

G21950

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G21950 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined before the certificate is signed. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5503 Elsrode Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5503 Elsrode Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CHARLES W. FLICHMAN, SR.

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-05-9549

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Minnie F. Flichman
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1870

8. AGE: Years	Months	Days	If less than one day
74	6	26	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired Shipping Clerk
11. Industry or business

FATHER
12. Name Andrew Flichman
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Braun
15. Birthplace Germany

16 (a) Informant Mr. Charles W. Flichman, Jr.
(b) Address 3308 Acton Rd., Parkville,

17 (a) Burial (b) Date thereof 10/27/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.,
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 26 1944 (b) Huntington Hill Registrar
(Date Rec'd by City Registrar)

VS 130

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Oct. 24, 1944, at 2:00M

21. I certify that death occurred on the date above stated; that I attended deceased from Jany No 1943, to Oct 24 1944 and that I last saw h[illegible] alive on Oct 17 1944.

Immediate cause of death Acute Cardiac Dilatation — Duration Oct 24/44y

Due to

Due to

Other Conditions Chronic Myocarditis (Arterio Sclerosis) — a number 7 years.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas B. Green M.D.
Address 3009 Evergreen Ave/ Date signed 10/26/44
Baltimore 14-Md

G21951

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G21951 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1828 Harlem Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1828 Harlem Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CLARA VIRGINIA RYAN

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: James F.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 2/9/1856

8. AGE: Years 88 | Months 3 | Days 16 | If less than one day hr. min.

9. Birthplace Emory, Carroll Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Samuel Nichols
13. Birthplace Reisterstown, Md.

MOTHER
14. Maiden Name Rachel Jones
15. Birthplace Emory, Carroll Co., Md.

16 (a) Informant Miss Maud Ryan
(b) Address 1828 Harlem Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 OCT 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1944 at 10:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 6 1944 to Oct 25 1944 and that I last saw ... alive on Oct 24 1944

Immediate cause of death: Chronic Cardio Vascular disease — Duration: 5 yrs.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Ernest W. Ryan

Address 735 Poplar Ln Date signed 10/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21952

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G21952
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3520 Hilton Rd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3520 Hilton Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANORA E. WALDEN

3 (b) If veteran, name war: none

3 (c) Social Security Account No. --

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 1855

8. AGE: Years: 89 | Months: 5 | Days: 13 | If less than one day: hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Jost Tschudy
13. Birthplace Norway

MOTHER
14. Maiden Name Theresa Wagner
15. Birthplace Germany

16 (a) Informant Mrs. Amelia Bosch
(b) Address Newfield, N. J.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Baltimore, Md.

19 OCT 26 1944 (Date rec'd by registrar) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from May 31 1944 to Oct 25 1944 and that I last saw h-r alive on Oct 24 1944

Immediate cause of death: pronchopneumonia — Duration: 10 days

Due to

Due to

Other Conditions: advanced arteriosclerosis ? hypertension duration ?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter L. Truxtun M. D.
Address 222 W Saratoga Date signed Oct. 26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

VS 150

G21953

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G21953

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2201 Mt. Holly St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Mt. Holly St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: LILLY S. McCAULLEY

3 (b) If veteran, name war: none

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William J.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 17, 1870

8. AGE: Years 74 | Months 8 | Days 8 | If less than one day hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: George W. Cruse
13. Birthplace: Balto., Md.

MOTHER
14. Maiden Name: Mary L. Mann
15. Birthplace: Louisiana

16 (a) Informant: Mr. William J. McCaulley
(b) Address: 2201 Mt. Holly St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 26 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 25, 1944, at 12:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2 1944, to Oct 25 1944 and that I last saw h-r alive on Oct 24 1944.

Immediate cause of death: Diabetes — about 4 yrs

Due to:

Due to: myocardial disease about 6 mo.

Other Conditions: advanced arterio sclerosis ?

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

Signature: Walter S. Hatfield M. D.
Address: 2220 Harrison Blvd
Date signed: Oct 26 1944

G21954

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1129

Registered No. G21954

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2501 Walbrook Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jane Martin

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 212-07-0554

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1878

8. AGE: Years	Months	Days	If less than one day
66	1	24	hr. min.

9. Birthplace Harford County, Maryland (Town, county, and state)
10. Usual Occupation Clerk
11. Industry or business New Amsterdam Casualty Co.

FATHER
12. Name James K. P. Martin
13. Birthplace Md.

MOTHER
14. Maiden Name Sarah D. Grafton
15. Birthplace Md.

16 (a) Informant Mr. Harry M. Grafton
(b) Address 2836 Maryland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory Center Cem., Location Forest Hill, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 26 1944 (Date rec'd by registrar) Huntington Williams, M.D. (Address)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1944, at 2:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1944, to 10-25 1944, and that I last saw her alive on 9-25 1944.

Immediate cause of death Shock

Due to Peloric peritonitis

Due to Autointoxication of stasis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Autointoxication, pelvic peritonitis

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. McCormack M. D.
Address Md. Gen. Hosp. Date signed 9-26-44

G21955

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1170

G21955

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Charles
(c) City or town Hughesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Christ

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband~~ or wife Gladys Christ
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-11-1895

8. AGE: Years	Months	Days	If less than one day
49	7	14	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Hard farmer
11. Industry or business none

FATHER
12. Name William Christ.
13. Birthplace Md

MOTHER
14. Maiden Name Mary Freeman
15. Birthplace Md

16 (a) Informant Mrs. Gladys Christ
(b) Address Hughesville - Md -

17 (a) Burial (b) Date thereof 10-27-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 535 Harford Road

19 (a) (b)
(Signature of registrar) (Registrar)

OCT 26 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1944, at 4:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1944, to Oct 25 1944, and that I last saw him alive on Oct. 25 1944.

Immediate cause of death, Terminal resulting in Resp failure

Duration

Due to Peritonitis - Diffuse

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operations:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Charles E Drake M. D.
Address Univ - Hospital Date signed 10/26/44

G21956

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 32a

G21956 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2235 Pelham Avenue #13
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2235 Pelham Avenue #13
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine White Foard

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	Widowed

6 (b) Name of husband or wife Aaron H. Foard
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1868

8. AGE: Years	Months	Days	If less than one day
76	4	17	hr. min.

9. Birthplace Baltimore Co. Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William White
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Barbour
15. Birthplace Maryland

16 (a) Informant Mrs. Charles R. Berlincke
(b) Address 2235 Pelham Avenue #13

17 (a) Burial (b) Date thereof 10/28/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) OCT 26 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1944 at 4:05 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1944 to Oct 25 1944 and that I last saw her alive on Oct 25 1944.

Immediate cause of death	Duration
Due to Broncho-pneumonia (acute)	Oct 24/44
Due to	
Other Conditions Influenza	Oct 21/44

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas B. Green M. D.
Address 3009 Eutaw Pl Ave Date signed 10/26/44
Baltimore 14 Maryland

C31957

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46a

Registered No. C31957

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Albuta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. [redacted] 3002 Arizona Ave
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Buschman, Mary Ann Buschman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: W.

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Henry F. Buschman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 17 - 1877

8. AGE: Years 67 ~~67~~ | Months 6 | Days 8 | If less than one day .....hr. .....min.

9. Birthplace.....
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name.....
13. Birthplace

MOTHER
14. Maiden Name.....
15. Birthplace

16 (a) Informant Mr. Henry F. Buschman

(b) Address 3002 Arizona Avenue

17 (a) Burial (b) Date thereof 10-27-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Baltimore

Location Baltimore

18 (a) Funeral director Leonard J. Rusk

(b) Address OCT 28 1944 Harford Road

19 (a)..... (b)..... A. Livingston Williams M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1944, at 2 P M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma of Esophagus

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury..... at..... M.

(b) Where did injury occur?.....

(c) Did injury occur at home, on farm, industrial place, in public place?..... While at work?.....

(d) Means of injury.....

23. Signature Robert Lee Graham M.D.
Medical Examiner.

Date signed Oct. 26 1944

PLEASE WRITE PLAINLY, with unfading ink. Be sure to state the causes of death clearly and legibly. Physicians: please write the correct age in especially important.

VS 151

G21958

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B

G21958 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2926 Keswick Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City ~~or town~~ BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2926 Keswick Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edwin Bell

3 (b) If veteran, name war —

3 (c) Social Security Account No 213-18-0333

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	White	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 23 1904

8. AGE: Years	Months	Days	If less than one day
40	8	3.	hr. min.

9. Birthplace Dorchester Co MD
(Town, county, and state)

10. Usual Occupation Driver.

11. Industry or business Sun Cab Co.

FATHER
12. Name John W. Bell
13. Birthplace MD.

MOTHER
14. Maiden Name Annie E. Mowbray
15. Birthplace MD.

16 (a) Informant Mrs. Annie E. Bell
(b) Address Cambridge MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29, 1944 (month) (day) (year)
(c) Cemetery or crematory Green Lawn
Location Cambridge MD.

18 (a) Funeral director Le Compte Funeral Service
(b) Address Cambridge, Maryland.

19 (a) (Date received) OCT 28 1944 (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1944, at 3:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1924 to Oct. 26 1944 and that I last saw h~~im~~er alive on Oct. 26 1944.

Immediate cause of death	Duration
(a) Mitral Insufficiency (Regurgitation)	24 yrs
Due to (b) Bronchial Asthma	26 days
Due to (c) Broncho Pneumonia	26 days

Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hermann D. Wantz M. D.
Address 2601 Manhattan Av. Date signed 10/26/44

G21959

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131 B

G21959 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lanvale Ave & Druid Lake Dr.
(c) Hospital or institution West Balto. Gen. Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2234 N. Monroe St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Stansbury

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife John E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1888

8. AGE: Years	Months	Days	If less than one day
56	1		hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Wm Birkmeyer
13. Birthplace Germany

MOTHER 14. Maiden Name Rebecca Krainer
15. Birthplace —

16 (a) Informant Mr. John E. Stansbury
(b) Address Sandywood Annapolis Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.26.44 (month) (day) (year)

(c) Cemetery or crematory Mt Olivet
Location Balto. Md.

18 (a) Funeral director Harry H. Wilson
(b) Address 4101 Edmondson Ave.

19 (a) (Inspector) (b) Huntington Williams, M.D.

OCT 26 1944

VS 105

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1944, at 6:00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1944 to 10/25 1944 and that I last saw h alive on 10/24 1944

Immediate cause of death Terminal Bronchopneumonia — Duration 7 day

Due Chronic Glom. Nephritis — ?

Due to Azotemia

Azotemia secondary

Other Conditions Dehydration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jimmy Taylor M.D.
Address WBGH Date signed 10/26/44

G21950 BALTIMORE CITY HEALTH DEPARTMENT G21950
Registered No.

CERTIFICATE OF DEATH 194a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days) year

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 St. Paul St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine A Rawlings

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Widow

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1907

8. AGE: Years	Months	Days	If less than one day
37	6	11	hr. min.

9. Birthplace Penna (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John C. McGinnis
13. Birthplace Pa.

MOTHER
14. Maiden Name Mary Tobin
15. Birthplace Pa.

16 (a) Informant Mrs. Carl Wolfe
(b) Address Emerson Hotel 811

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Balto. Md.

18 (a) Funeral director Harry H. Witzke
(b) Address 4101 Edmondson Ave

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

OCT 26 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1944, at 7.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/24 1944, to 10/24 1944, and that I last saw h.r alive on 10/24 1944.

Immediate cause of death Coronary Occlusion — Duration

Due to

Due to

Other Conditions Chronic Alcoholic

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address [illegible] Date signed 10-27-44

Signed: H. L. Wollenweber M.D
per R. L. Yates M.D. Oct. 26 1944

G21961 — BALTIMORE CITY HEALTH DEPARTMENT — Harris — G21961 Registered No.

CERTIFICATE OF DEATH 97

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 102 Longwood Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Whole life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 102 Longwood Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) V
If yes, name country

3 (a) FULL NAME Alice Patterson Harris

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. widow

6 (b) Name of husband or wife W. Hall Harris

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1855

8. AGE: Years 88 | Months 10 | Days 7 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Henry Patterson
13. Birthplace Maryland

MOTHER 14. Maiden Name Mary Louisa Wilson
15. Birthplace Maryland

16 (a) Informant W. Hall Harris Jr.
(b) Address 433 Tittle Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 1944 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins Sons Co
Address 1411 Eutaw Place
OCT 26 1944 (b) Signature for Williams, M.D.
19 (a) (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 25 1944, at 6-15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 21 1943 to Oct. 25 1944, and that I last saw her alive on Oct. 25 1944.

Immediate cause of death	Duration
(a) Terminal Bronchopneumonia	1 day
Due to (b) Senile Arteriosclerosis	Apparent
Due to (c) —	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation No
Major findings of operation
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external cause, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature W. Gibson Porter, M. D.
Address 4822 Roland Ave Date signed 10/26/44

G21962

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G21962 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave. & John St.
(c) Hospital or institution Hospital for the Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 59 yrs. ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3908 N. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Jane James Cook

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-15-(1885)

8. AGE: Years	Months	Days	If less than one day
59	3	10	hr. min.

9. Birthplace Fort Slocum New York (Town, county, and state)
10. Usual Occupation None.
11. Industry or business

FATHER
12. Name Capt. Geo Hamilton Cook
13. Birthplace Lockport N.Y.

MOTHER
14. Maiden Name Jane James
15. Birthplace St James Phelps Co Mo.

16 (a) Informant Dr. J. E. Haines.
(b) Address Lutherville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28 1944 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto Md

18 (a) Funeral director Henry W. Jenkins & Sons Co
(b) Address McCulloh & Richard Sts.

19 OCT 30 1944 Registrar Williams, M.D.

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1944, at 10 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 1944 to 10-25 1944, and that I last saw h[illegible] alive on 10-25 1944

Immediate cause of death Cerebral vascular accident (hemorrhage)
Due to Hypertension Cardio-Vascular disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. S. Speed III M. D.
Address Women's Hospital Date signed 10-25-44

G21963 BALTIMORE CITY HEALTH DEPARTMENT G21963

CERTIFICATE OF DEATH 1937

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town OWINGS MILLS (If outside city or town limits, write RURAL and give town)
(d) Street No. — (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) FULL NAME ROBERT LEE RANDOLPH

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 212-10-8722

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of ~~husband or~~ wife: [illegible] RANDOLPH
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) MAY 19, 1895

8. AGE: Years	Months	Days	If less than one day
49	5	7	— hr. — min.

9. Birthplace BALTIMORE, MD (Town, county, and state)
10. Usual Occupation EXECUTIVE
11. Industry or business ARCHERS LAUNDRY

FATHER
12. Name DR. ROBERT L. RANDOLPH
13. Birthplace MARYLAND

MOTHER
14. Maiden Name PHOEBE ELIOTT
15. Birthplace SOUTH CAROLINA.

16 (a) Informant JULIA McHENRY RANDOLPH
(b) Address OWINGS MILLS, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28 1944 (month) (day) (year)
(c) Cemetery or crematory St Thomas
Location Garrison Forest

18 (a) Funeral director Henry McCubbin Funeral Home
(b) Address McCulloh & Eutaw Sts

19 (a) Oct 28 1944 (Date received by registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 26 1944, at 1:53 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/1944 to 10/26/1944, and that I last saw him alive on 10/25/1944.

Immediate cause of death	Duration
CARDIO-RESPIRATORY FAILURE	12 HRS.
Due to CONGESTIVE HEART FAILURE	12 HRS.
Due to HYPERTENSIVE CARDIO-VASCULAR DISEASE	14 YRS.
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation —
of autopsy NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. W. Morgan Jr. M. D.
Address 332 E. University Pkwy Date signed 10/26/44

G21964

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 94a

G21964
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 5002 Frederick Road
(b) Street address Attnd, Baltimore 29
(c) Hospital or institution:
The Gundry Sanitarium
(d) Length of stay in hospital or inst. (yrs., mos., or days) 36 days
(e) Length of stay in Baltimore (yrs., mos., or days) 38 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Altoona
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2717 W. Chestnut
(If rural give location)
(e) If foreign born, how long in U. S. A.? years.

3 (a) FULL NAME M. Gertrude La Van

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	white	married

6 (b) Name of husband or wife Carl P. La Van
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 8 1881

8. AGE: Years	Months	Days	If less than one day
62	10	18	hr. min.

9. Birthplace Pennsylvania
(Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER
12. Name John Eckhardt
13. Birthplace Pa

MOTHER
14. Maiden Name Sarah Hostetter
15. Birthplace Pa

16 (a) Informant Maude Yates
(b) Address Altoona Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28/44 (month) (day) (year)
(c) Cemetery or crematory Rose Hill Cemetery
Location Altoona Pa.

18 (a) Funeral director John Antes Sons
(b) Address 900 Eldrow Place

19 (a) OCT 26 1944 (Date received by Registrar) Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 1944, at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 17 1944, to Oct. 26 1944, and that I last saw h.. alive on Sept Oct 26 1944.

Immediate cause of death	Duration
Coronary thrombosis	12 hours
Due to Arteriosclerosis	
Due to	
Other Conditions Had been depressed + nervous for months	

(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ralph K. Gundry M. D.
Address 5002 Frederick Rd, Balto 29 Date signed 10-31-44

G21965

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G21965
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 109 W. Ostend St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore 30
(If outside city or town limits, write RURAL and give town)
(d) Street No. 109 W. Ostend St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Shaw

3 (b) If veteran, name war: No
3 (c) Social Security Account No. 705-07-9457

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Mattie (Millie) Shaw
6 (c) If dead, give age 62 years

7. Birth date of deceased (mo., day, yr.) Aug 13, 1882

8. AGE: Years	Months	Days	If less than one day
64	2	12	..... hr. ..... min.

9. Birthplace England (Town, county, and state)
10. Usual Occupation Pilot & Engineer
11. Industry or business

FATHER
12. Name George Shaw
13. Birthplace England

MOTHER
14. Maiden Name Emma Forrest
15. Birthplace England

16 (a) Informant Millie A. Shaw
(b) Address 109 W Ostend St (30)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem
Location Balto Md.

18 (a) Funeral director A. Howard Evans
(b) Address 1400 S. Charles St. Balto 30

19 (a) OCT 26 1944 (Date received by Registrar) Hunting for Williamson, M. (b) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25, 1944, 6.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 25 1944
and that I last saw him alive on Oct 25, 1944.

Immediate cause of death: Coronary Thrombosis

Duration: 25 min

Due to: Senile Myocardial Deg 2 mos

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. Lawrence
Address 10 E. Fayette St
Date signed Oct 26/44

460806 G21966

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X 20 G21966

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State S. C. (b) County
(c) City or town Charleston (If outside city or town limits, write RURAL and give town)
(d) Street No. 70 Inodd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur Young

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-8-11

8. AGE: Years	Months	Days	If less than one day
33	2	18	hr. min.

9. Birthplace S. C. (Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name Arthur R. Young.
13. Birthplace Penn

MOTHER
14. Maiden Name Nannie Conner
15. Birthplace S. C.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/26/44. (month) (day) (year)
(c) Cemetery or crematory
Location Charleston S. C.

18 (a) Funeral director Wm. J. Thomas & Son
(b) Address North & Pennsylvania Ave. Baltimore, Md.

OCT 26 1944 (Date filed by Registrar) (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1944, at 1240 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 15 1944, to Oct. 26 1944, and that I last saw him alive on Oct. 26 1944.

Immediate cause of death	Duration
Embolic vascular accident	
Due to Pelvic inflamatory mass involving bladder	
Due to Colostomy for obstructive colitis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-9-44
Major findings of operation: Large inflamatory mass,
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Handelman M. D.
Address J H H Date signed 10-29-44

G21967 YOSELOWITZ.

G21967

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4409 Frederick Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4409 Frederick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fanny Yoselowitz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Yoselowitz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name —
13. Birthplace Russia

MOTHER
14. Maiden Name
15. Birthplace Russia

16 (a) Informant Albert Yoselowitz
(b) Address 4411 Frederick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-27-44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location

18 (a) Funeral director Jos. Levin Inc
(b) Address 1439 E. Baltimore St

19 (a) Date received by registrar Huntington Williams, M.D.

OCT 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1944, at 8:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Oct 26 19 44
and that I last saw h alive on 10/26 19 44

Immediate cause of death: Cerebral Hemorrhage — Duration 4 da.

Due to: Hypertensive Cardio — 5 years

Due to: Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Bonelli M. D.
Address 412 Frederick Ave Date signed 10/26/44

G21968

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30F

G21968
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Sydenham Hosp. 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2445 Etting St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Theresa Catlett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	

6 (b) Name of husband or wife: July 1944

6 (c) If alive give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
	3 mos		hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Owen Link
13. Birthplace North Carolina

MOTHER
14. Maiden Name Jean Catlett
15. Birthplace Baltimore Md

16 (a) Informant Sydenham Hospital
(b) Address Hetzing Run + Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location West Cor

18 (a) Funeral director Brooks
(b) Address 1463 N. Carey St

(a) Date received by Registrar OCT 27 1944 (b) Registrar Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 - 25 1944 at 2.39 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1944, to 10-25 1944, and that I last saw her alive on 10-25 1944.

Immediate cause of death	Duration
Bronchopneumonia	
Due to pneumococcus Type 4	
Pertussis	
Due to	
Other Conditions Anemia cong. Syphilis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John R. Birmingham M.D.
Address J.H.H. Date signed 10/25

G21969

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92 B Registered No. G21969

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore, Md.
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 225 S. Howard St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Philips

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 26 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) OCT 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1944, at 8:30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Valvular Heart Disease
Mitral Insufficiency.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer, M.D. Medical Examiner.
Date signed October 15, 1944.

2265

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21970 X ✓ G21970

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town Baltimore Brooklyn Park
(If outside city or town limits, write RURAL and give town)
(d) Street No. 918 Victory ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roy Jones

3 (b) If veteran, name war —

3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Ruth Roff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14, 1909

8. AGE: Years	Months	Days	If less than one day
35	5		hr. min.

9. Birthplace Atlanta, Ga.
(Town, county, and state)

10. Usual Occupation Erector

11. Industry or business Shipyard

FATHER
12. Name Unknown Jones
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Mrs. Roy Jones
(b) Address 922 Victory Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 26 1944

18 (a) Funeral director Commissioner of Health

(b) Address

19 (a) OCT 27 1944 (b) Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-14- 1944, at 7 20 P M

21. I certify that I took charge of the remains described above, held an Partial autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐, and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Hemmorhaging Gas

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-14- at P M.
(b) Where did injury occur? 638 N. Fayette St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas range jets

23. Signature Howard J. Wilkins M.D.
Medical Examiner.
Date signed 10-15-44

2267

G21971

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77

G21971 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Md.
(c) Hospital or institution Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 13 N Bond St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Adams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901

8. AGE: Years 43 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 26 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 27 1944 (Date rec'd by registrar) (Signature) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 12, 1944, at 4:40 P M

21. I certify that I took charge of the remains described above, held an Partial Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Chronic Alcoholism.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H L Wallenmeyer M.D.
for Medical Examiner.
Date signed October 13, 1944

VS 151

2266

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21972 ✓ G21972

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Edgewood Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Woodlawn (If outside city or town limits, write RURAL and give town)
(d) Street No. 6205 Windsor Mill Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME FLORENCE V. HOOKER

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Louis Hooker
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 29, 1859

8. AGE: Years	Months	Days	If less than one day
84	9	25	hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Noah Bull
13. Birthplace Md.

MOTHER
14. Maiden Name Anna ?
15. Birthplace Md.

16 (a) Informant Mrs. Frank Rau
(b) Address 6205 Windsor Mill Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

OCT 27 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24, 1944, at 8:00 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 18 1944 to Oct 24 1944 and that I last saw her alive on Oct 24 1944

Immediate cause of death: Thrombus Myocarditis Duration

Due to

Due to

Other Conditions Pulmonary Edema Ruby
Thrombus Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. E. Richardson M.D.

Address 1100 W. 25th St Balto Date signed Oct 26 1944

G21973

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21973 Registered No. 83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 415 Lyndhurst St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 425 Lyndhurst St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME SARAH MARSALINE JONES

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jan. 31, 1865

8. AGE: Years: 79 Months: 8 Days: 25 If less than one day: hr. min.

9. Birthplace: Harford Co. (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles W. Harward
13. Birthplace: Harford Co., Md.

MOTHER
14. Maiden Name: Harriet James
15. Birthplace: Harford Co.

16 (a) Informant: Mrs. Harriet Koons
(b) Address: 415 Lundhurst St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/29/44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Zion
Location: Belair, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 27 1944 (Date received by registrar) (b) Pennington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 26, 1944, at 5:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 17 1944 to Oct 26 1944; and that I last saw h[illegible] alive on Oct 22 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	5 min.
Antecedent Conditions	
Due to Hypertension	
Due to Arteriosclerosis	1 year
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature A. C. Smith M. D.
Address 4509 Belair Rd Date signed Oct 26

G21974 -

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(new) G21974 Registered No. 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave. 12

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 13.25 yrs 3 mos.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 3220 Barclay St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lucy Richardson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F

5. Color or race: C

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 2 2 1880

8. AGE: Years 64 | Months ? 1 | Days ? 22 | If less than one day, hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name James W. Jennings
13. Birthplace Md.

MOTHER
14. Maiden Name Margaret Moore
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-27-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director Robert E. Jennings
(b) Address 501 Madison Ave

19 (a) Date received by Local Registrar (b) Signature of Local Registrar (Mrs. Hunting for Williams M.D.)

OCT 27 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/24 1944 at 1 00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/28 1931 to 10/24 1944, and that I last saw he alive on 10/24 1944.

Immediate cause of death Tumor of R. ovary; hypertensive cardiovascular disease — Duration

Due to

Due to

Other Conditions hydatidiform mole; pregnancy, 3 months (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: same as above plus myoma of uterus

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. E. Perry J.

Address City Hosp. Date signed 10/26/44 M.D.

PHYSICIAN

Underline the cause to which death should be charged statistically.

975

AB-60588

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

Registered No. G21975

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr-7mos-9days
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 648 Bradley St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

1924

3 (a) FULL NAME William Salter

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widower

6 (b) Name of husband or wife Elizabeth (D)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?- ?- (70?)

8. AGE: Years	Months	Days	If less than one day: hr.	min.
70 ?	?	?		187+

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Salter
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth ?
15. Birthplace Maryland

16 (a) Informant Baltimore City Hospitals (Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md.

18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania Ave

OCT 27 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25- 1944, at 3.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-16 1944 to 10-25- 1944 and that I last saw h- im alive on 10-25- 1944

Immediate cause of death: a. Cerebral accident (Probably cerebral Thrombosis) Duration 3 days
Due to C.N.S. Lues ?
Due to
Other Conditions generalized arterio-sclerosis - bronchopneumonia ?
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: yes yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.A. Perry M.D.
Address City Hosp. Date signed 10/26 M.D.

C21976

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

115 C

Registered No. C21976

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: DOA University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 907 Sharp St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME May Rolle

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: [illegible] | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1904

8. AGE: Years 40 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Jamestown N C (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Henry Wilson
13. Birthplace N.C.

MOTHER
14. Maiden Name Edna Thomas
15. Birthplace N.C.

16 (a) Informant Walter Tripps
(b) Address 907 Sharp St

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)
(c) Cemetery or crematory Norfolk
Location Va.

18 (a) Funeral director Isaiah T. Brown & Son
(b) Address 1050 Montgomery St

19 OCT 27 1944 (Date rec'd by registrar) (b) Hunting Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/22 1944, at 11.20 P M

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to 79 hrs. death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Follicular Tonsillitis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Talley M.D. Medical Examiner.
Date signed 10/23/44

VS 151

PLEASE WRITE PLAINLY, WITH INK ALONG LINE. Entries must be complete and correct as to the causes of death clearly and legibly. Physicians: please write the cause of death as especially important.

G21977 LINNBAUM

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

Registered No. G21977

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves.
(c) Hospital or institution: St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Relts.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2688 Eagle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Linnbaum

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Anna Elizabeth

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1887

8. AGE: Years 57 | Months 7 | Days 23 | If less than one day: hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Tool Setter, Mgr

11. Industry or business

FATHER
12. Name Anthony Linnbaum
13. Birthplace Germany

MOTHER
14. Maiden Name Clotomia Imhoff
15. Birthplace Maryland

16 (a) Informant Mrs Anna E Linnbaum
(b) Address 2688 Eagle st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-44 (month) (day) (year)
(c) Cemetery or crematory Bath Nath Cem
Location Baltimore Md

18 (a) Funeral director Geo A Foley
(b) Address Fulton Ave Fayette

OCT 27 1944 (Date received by registrar) (b) Huntington Williams M.D. (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1944, at 12:50 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-19 1944 to 10-26 1944, and that I last saw h[illegible] alive on 10-26 1944.

Immediate cause of death	Duration
Post operative shock	
Due to Carcinoma caecum	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-21-44

Major findings of operation: Carcinoma caecum

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Howard W Stier M. D.
Address St Agnes Hosp Date signed 10-26-44

G21978

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G21978

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2025 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1929 Jefferson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife None

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/31/91

8. AGE: Years	Months	Days	If less than one day
53	89	2725	hr. min.

9. Birthplace Balto
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Francis X. Smith
13. Birthplace Baltimore

MOTHER
14. Maiden Name Katherine Trochlinger
15. Birthplace Baltimore

16 (a) Informant Richard A. Trochlinger
(b) Address 107 N. Monroe

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Eutaw St.

19 (a) (Date received by Registrar) (b) OCT 27 1944

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1944, at 4:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23/44 19 , to 10/25 1944, and that I last saw h.e.r. alive on 10/25/44 19

Immediate cause of death Acute diffuse peritonitis — Duration

Due to Intestinal obstruction and perforation

Due to Secondary carcinoma gut by Carcinoma

Other Conditions Diabetes Mellitus
(Include pregnancy within 3 months of death)

Date of operation 10/21/44

Major findings of operation: Intestinal Obstruction Carcinoma of cecum

of autopsy: Peritonitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Frances L. Greenbaum M. D.

Address Date signed

Huntington Williams, M.D.

Thon

G21979

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1939

G21979 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 Hollins St.
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-4
(e) Length of stay in Baltimore (yrs., mos., or days) 70 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 Hollins St. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Christian Thon

3 (b) If veteran, name war: —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Mary Thon
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 25 1867
8. AGE: Years 77 Months 7 Days 10 If less than one day: hr. min.
9. Birthplace: Philadelphia, Pa. (Town, county, and state)
10. Usual Occupation: Glass worker
11. Industry or business:

FATHER
12. Name: William Thon
13. Birthplace: Germany

MOTHER
14. Maiden Name: Louise Kaufelt
15. Birthplace: Germany

16 (a) Informant: Mrs Mary Thon
(b) Address: 1721 Hollins St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory: Mt Olivet Cem
Location: 2900 B. Baltimore Ave
18 (a) Funeral director: John J. Conway Son
(b) Address: 901-03 Hollins St.
19 (a) (Date received by registrar) 10-27-1944 (b) Registrar: Huntington Williams

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1944 at 11 Pt. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1943 to Oct 25 1944, and that I last saw h im alive on Oct 24 1944.

Immediate cause of death	Duration
Arteriosclerotic myocarditis	?
Due to Generalized arteriosclerosis	?
Due to —	
Other Conditions —	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence —
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Schrader M. D.
Address 548 S. Fulton Ave Date signed 10-26-44

G21980

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

163H

G21980 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5946 Kavon Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5946 Kavon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ethel Bozett Engelhardt

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Divorced
6 (b) Name of husband or wife —
6 (c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Oct. 5th 1898
8. AGE: Years 46 | Months 0 | Days 21 | If less than one day ____hr. ____min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Robert W. Bozett
13. Birthplace Virginia

MOTHER
14. Maiden Name Elizabeth Harris
15. Birthplace Virginia

16 (a) Informant Mr. Carroll W. Bozett
(b) Address 411 Edgewood Ave. Millersville, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30th 1946 (month) (day) (year)
(c) Cemetery or crematory Bozett Family Cemetery
Location Millersville Virginia

18 (a) Funeral director Langdon Funeral Home
(b) Address 7401 Belair Road

19 (a) Filed OCT 27 1946 Huntington Hitt M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1946, at 6:55 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation

Due to Ammunting gas

Other Conditions Dependent

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-26- at P.M.
(b) Where did injury occur? 5946 Kavon Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhalation - gas - kitchen range

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 10-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G21981

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G21981

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 McCulloh St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1708 McCulloh St.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Grace V. Blackston

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Geo. H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 26, 1877

8. AGE: Years 67 | Months 8 | Days 29 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

12. Name Mary M. L. King

13. Birthplace Richmond, Va.

14. Maiden Name Williams H. Booker

15. Birthplace Petersburg Va

16 (a) Informant Evelyn B. Jefferson

(b) Address 1651 Gilmor Ave, Baltimore Md

17 (a) Burial (b) Date thereof Oct. 27, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Park
Location Baltimore Co. Md.

18 (a) Funeral director Mrs. Geo. H. Holland

(b) Address 1631 Druid Hill Ave.

19 OCT 27 1944 Huntington for Williams M.D.
(Date rec'd by registrar) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1944 at 12½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1944, to Oct 24 1944, and that I last saw her alive on Oct 24 1944.

	Duration
Immediate cause of death: Myocardial insufficiency	30 days
Due to: Essential hypertension	2 mos.
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Eug. H. Pemberton M. D.

Address 632 Druid Hill Ave Date signed 10-26-44

G21982 88851

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

132

Registered No. G21982

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 - 18
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2302 McCulloh St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie Leonard Williams

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife: Alvin
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1910

8. AGE: Years 33 | Months 10 | Days 5 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER: 12. Name Milton Leonard
13. Birthplace Md.

MOTHER: 14. Maiden Name Sue Baylord
15. Birthplace Penna.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Mary Gus. St. Stella
(b) Address 631 Druid Hill Ave.

OCT 27 1944 (Date received by Registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1944 at 12:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Oct 23 1944, and that I last saw h[illegible] alive on Oct 23 1944.

Immediate cause of death	Duration
Heart failure	
Due to Pulmonary tuberculosis	1 year
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harold Dillon M.D.
Address Balto City Hosp Date signed 10/24/44

G21983

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G21983

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1120 N. Monroe St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1120 N. Monroe St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** James J. Jackson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Nina

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1873

8. AGE: Years 71 | Months 1 | Days 2 | If less than one day: hr. min.

9. Birthplace Baydon, Va (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Nina Jackson
(b) Address 1120 N. Monroe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 27, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Mrs. Laya. H. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) OCT 27 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 1944, at 4.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 15 1944, to Oct 24 1944, and that I last saw h.m alive on Oct 23 1944

Immediate cause of death	Duration
Coronary Occlusion	4 hrs
Due to Cardio-Vascular	
Due to Renal Disease	4 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. P. Hughes M.D.
Address 825 N. Fremont Ave Date signed 10/27/44

G21984

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 300

G21984
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write th... the causes of death clearly and legibly. Specify the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Williams & Caton Aves.
(c) Hospital or institution St. Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 436 Overbrook Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Henze

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Caroline M. Henze
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 16/1869

8. AGE: Years	Months	Days	If less than one day
74	10	10	hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Foreman Metzgestner Markets

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Charles H. Henze
(b) Address 436 Overbrook Road

17 (a) Burial (b) Date thereof Oct 30/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Harry R. Armand
(b) Address 704 Ridgewood Ave

19 (a) OCT 27 1944 (b) Huntington Williams Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1944 at 1:[illegible] M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1944 to 10/26 1944 and that I last saw h[illegible] alive on 10/26 1944.

Immediate cause of death Dissecting aneurysm of the aorta

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy: Dissecting aneurysm

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stier M. D.
Address St Agnes Hosp Date signed 10-26-44

G21985

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G21985 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 54 Bloomsbury

(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14

(e) Length of stay in Baltimore (yrs., mos., or days) 63 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County —

(c) City or town Balto. Md. (If outside city or town limits, write RURAL and name town)

(d) Street No. 54 Bloomsbury (If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Johnson Titchett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Married

6 (b) Name of husband or wife Nellie Titchett (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/25/863

8. Age: Years	Months	Days	If less than one day
80	4	21	hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name —

13. Birthplace

MOTHER

14. Maiden Name —

15. Birthplace

16 (a) Informant Nellie Titchett

(b) Address 54 Bloomsbury

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md

18 (a) Funeral director Wm. H. Kelson

(b) Address 1303 Pennsylvania Ave

19 (a) (Signature) (b)

OCT 27 1944

VS 150

Hunting for Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28/44 19 at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25/44 to 10/28/44 19 44

and that I last saw — alive on 10/28/44

Immediate cause of death

(a) Coronary Thrombosis

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration between onset and death?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. Lee Williams M.D.

Address 1303 Penna Ave Date 10/28/44

G21986

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 74a

Registered No. G21986

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33RD & CALVERT STS.
(c) Hospital or institution: UNION MEMORIAL HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 DAYS
(e) Length of stay in Baltimore (yrs., mos., or days) 5 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTIMORE
(c) City or town TOWSON
(If outside city or town limits, write RURAL and give town)
(d) Street No. 107 BURKE AVE.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS COTTINGHAM ~~CUNNINGHAM~~ STEVENSON

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	SINGLE

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 19, 1876

8. AGE: Years	Months	Days	If less than one day
68	9	7	— hr. — min.

9. Birthplace TOWSON, BALTO. CO.; MD.
(Town, county, and state)

10. Usual Occupation FLORIST

11. Industry or business OWN

FATHER
12. Name JOHN N. STEVENSON
13. Birthplace MARYLAND

MOTHER
14. Maiden Name ANNIE ~~CUNNINGHAM~~ Cottingham
15. Birthplace MARYLAND

16 (a) Informant MRS. WILLIAM NORRIS
(b) Address 107 BURKE AVE. TOWSON, MD.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28 1944 (month) (day) (year)
(c) Cemetery or crematory Govans Presbyterian
Location Baltimore, Maryland

18 (a) Funeral director John Burns' Sons
(b) Address Towson Maryland

OCT 27 1944 (Date rec'd by registrar) (Signature) for William H.P. (Registrar)

VS 158

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 26 1944 at 7:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21/1944 to 10/25/1944 and that I last saw him alive on OCT. 25 1944.

	Duration
Immediate cause of death CARDIO-RESPIRATORY FAILURE	5 DAYS
Due to CARDIAC FAILURE	5 DAYS
Due to CHRONIC MYELOGENOUS LEUKEMIA	4 Mos.
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Geo. W. Youngstrom Jr. M. D.
Address 332 E. University Pkwy Date signed 10/26/44

G21987 - 90545

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

G21987 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 23
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 171 W. Hamburg St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Jones

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Allen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 22, 1922

8. AGE: Years	Months	Days	If less than one day
22	5	1	hr. min.

9. Birthplace N. C.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Jasper Long
13. Birthplace N. C.

MOTHER
14. Maiden Name Pinkie Long
15. Birthplace N. C.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 27 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs Kate R. Williams
(b) Address 322 N. Schroeder St.

19 (a) Oct 25 1944 (Date filed by Registrar) (b) Huntington Williams Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 23, 1944, at 7:15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-23 1944, to 10-23 1944, and that I last saw h[illegible] alive on 10-23- 1944

Immediate cause of death Miliary tuberculosis — Duration ?

Due to

Due to

Other Conditions Pyogenic pneumonia 8a day pst partum
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. M. Phillips M. D.
Address Balt City Hosp Date signed 10-24-44

G21988

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G21988

83a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 9 N. Bruce St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 9 N. Bruce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Vaughn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race Colored

6 (a) Single, married, widowed, or divorced. (married)

6 (b) Name of husband or wife Elizabeth Vaughn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 1890

8. AGE: Years 54 | Months 6 | Days 20 | If less than one day hr. min.

9. Birthplace Hampton Va
(Town, county, and state)

10. Usual Occupation Minister

11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name Catherine (Vaughn)
15. Birthplace Virginia

16 (a) Informant Elizabeth Vaughn
(b) Address 9 N Bruce St

17 (a) Burial **(b) Date thereof** Oct 27, 19
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Kate R. Williams
(b) Address 322 N Schroeder St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 24 19 44, at 12 3/4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 3 1944, to Oct 1944, and that I last saw him alive on Oct 23 1944

Immediate cause of death	Duration
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other Conditions Colitis	9 mo.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Douglas Sheppard M. D.
Address 1631 W Franklin St Date signed 10/27/44

VE 3

G21989

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1108

G21989 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1907 Eager St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Mc Kenna McKinnon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widower

6 (b) Name of husband or wife Julia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1893

8. AGE: Years	Months	Days	If less than one day
51	4	21	hr. min.

9. Birthplace N. C. (Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name Joseph McKinnon
13. Birthplace N. C.

MOTHER
14. Maiden Name Mary Ellis
15. Birthplace N. C.

16 (a) Informant Venny Chandler
(b) Address 1907 E Eager St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A Ellis
(b) Address 1129 N Caroline St.

19 (a) (b)

OCT 27 1944 Registrar

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1944, at 8 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Purulent otitis media, right; purulent meningitis;

Lobar pneumonia, right

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
Means of injury

23. Signature Robert L. Greaton M.D. Medical Examiner.
Date signed 10-26-44

FILL IN WITH CARE, WRITE CONTINUOUSLY AND CONFORMING TO ENGLISH. Information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21990 Joseph Compher G21990

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 131 a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1314 Division
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2172 No. Fremont Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) No
If yes, name country

3 (a) FULL NAME Joseph Compher

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-14-3309

4 Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Viola Jones

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 16, 1904

8. AGE: Years 40 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name William Compher

13. Birthplace Maryland

MOTHER 14. Maiden Name Agnes Hanks

15. Birthplace Baltimore, Md

16 (a) Informant Miss Grace Compher

(b) Address 1117 Fremont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/27/44 (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem'l. Pk.

Location Balto. County, Md

18 (a) Funeral director Charles G. Cooper

(b) Address 512 N. Carrollton Ave.

OCT 27 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 24 1944 at 1.10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-1 1944 to 10-24 1944, and that I last saw h alive on 10-24 1944.

Immediate cause of death: Hypertension Intracerebral Hemorrhage — Duration: Past 24 hrs

Due to: Nephritis

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Charles J. Wendler M. D.

Address 511 Dulaney Date signed 10-27-44

G21991

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21991 110a

Registered No. G21991

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE + OLIVER ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 N. KENWOOD AVE. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME MR. WILLIAM SASS

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife JOSEPHINE SASS
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) AUG 19th 1884

8. AGE: Years	Months	Days	If less than one day
60	2	6	hr. min.

9. Birthplace BALTO. MD (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Charles Sass
13. Birthplace Md Hannipman

MOTHER
14. Maiden Name Catherine [illegible]
15. Birthplace Md

16 (a) Informant Mrs Josephine Sass
(b) Address 1312 N Kenwood Ave

17 (a) Burial (b) Date thereof Oct 25th 1944 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Frederick Road

18 (a) Funeral director Leo G. Brook
(b) Address 1701-03 N. Patt. Park Ave.

19 7 1944 (b) Registrar
(Date rec'd by reg.)
Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 25 1944, at 2.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/15/1944 to 10/25/1944, and that I last saw h. alive on 10/25 1944.

Immediate cause of death	Duration
RESPIRATORY FAILURE	
Due to LUNG ABSCESS	
Due to EMPYEMA	
Other Conditions ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. C. Robertson M. D.
Address St. Joseph Hosp Date signed 10-25-44

G21992

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓170 C

Registered No. G21992

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Thirty-Third St.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4200 Elm Terrace (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Howard David James

3 (b) If veteran, name war

3 (c) Social Security Account No. 265-09-6739

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Gertrude Hazel James
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) January 26, 1881

8. AGE: Years	Months	Days	If less than one day
63 ~~44~~	8	29	hr. min.

9. Birthplace Youngstown, Ohio (Town, county, and state)
10. Usual Occupation Supt. - Forge Shop
11. Industry or business The Belmar Corporation

FATHER
12. Name David T. James
13. Birthplace Youngstown, Ohio

MOTHER
14. Maiden Name Annie Jones
15. Birthplace Youngstown, Ohio

16 (a) Informant Mrs. Gertrude H. James
(b) Address 1798 Crawford Road Cleveland, Ohio

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Knollwood Cemetery
Location Cleveland, Ohio

18 (a) Funeral director Phillip Lamonaca
(b) Address 4510 Liberty Heights Ave.

19 (Filed) OCT 27 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 1944, at 8 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Acute intestinal obstruction

Due to Fracture of pelvis, fracture of 8th Thoracic vertebra

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury October 22, 1944 M.
(b) Where did injury occur? Falls Rd & 42nd St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No 13-8
(d) Means of injury Struck by auto.

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 10-12-44

G21993

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V 157 e

G21993 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. V
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2339 Sidney Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carroll Hancock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife. —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 25. 1944

8. AGE: Years	Months	Days	If less than one day
	2	1	hr. min.

9. Birthplace Delaware
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Geo Hancock
13. Birthplace Delaware

MOTHER 14. Maiden Name Ruth Heartsuny
15. Birthplace Va

16 (a) Informant Mrs Ella Franz.
(b) Address 2337 Sidney

17 (a) Burial, Removal (b) Date thereof 10/28/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Cory Cem
Location Frankford Del

18 (a) Funeral director Ulbrich Funeral Home
(b) Address 2008 Orleans St

19 OCT 27 1944 (b) Huntington for Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Oct. 26 1944, at 10 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Congenital Heart Disease (Transposition of great vessels, patent ductus arteriosus, patent foramen ovale)

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Grahame M.D.
Medical Examiner.
Date signed Oct. 26 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21994

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55L

G21994

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/27/44
(e) Length of stay in Baltimore (yrs., mos., or days) Since 8/27/44

2. USUAL RESIDENCE OF DECEASED:
(a) State Iowa (b) County
(c) Street: 1401- 2nd St., S.E.,
(If outside city or town limits, write RURAL and give town)
State: Cedar Rapids, Iowa
(d) No.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME WALTER MORRIS BRIM

3 (b) If veteran, name war

3 (c) Social Security Account No. 485-09-9741

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1911

8. AGE: Years	Months	Days	If less than one day
33	5	26	hr. min.

9. Birthplace Islaco, Mo.
(Town, county, and state)
10. Usual Occupation Oiler
11. Industry or business Merchant Marine

FATHER
12. Name Edward Brim
13. Birthplace Fairfield, Iowa

MOTHER
14. Maiden Name Winifred Wright
15. Birthplace ? Ill.

16 (a) Informant Records, U.S.Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-44 (month) (day) (year)
(c) Cemetery or crematory Lynwood Cemetery
Location Cedar Rapids Iowa

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Rd

19 (a) (b) Huntington Williams, M.D.
(Signature of Registrar)

OCT 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25, 1944, at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug.27, 1944 to Oct.25, 1944, and that I last saw him alive on Oct.25, 1944.

Immediate cause of death Lymphoblastoma-Reticulum cell sarcoma involving the heart, lungs and most of organs of the body.

Duration Since Feb. 1944

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Van Ackeren M. D.
Address Baltimore, Md. Date signed 10/25/

MS-55124

G21995

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1936

G21995

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1506 E. Pratt St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Polly Horton

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1860

8. AGE: Years	Months	Days	If less than one day
84			hr. min.

9. Birthplace Johnson Co. N. C
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Needham Lee
13. Birthplace N. C

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Ella Horton
(b) Address 416 N. Bond St.

17 (a) Burial (b) Date thereof 10/29/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Raleigh, N. C.

18 (a) Funeral director Elroy C. Wilson
(b) Address 1000 Brentley ave

19 OCT 27 1944 (b) Huntington Williams, M.D.
(Date rec'd by Reg'r) Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1944 at 9 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1944 to Oct 25 1944, and that I last saw her alive on Oct 25 1944

Immediate cause of death Generalized arteriosclerosis

Due to

Due to

Other Conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. H. Warfield M. D.
Address Provident Hospital Date signed 10/26/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21996 170 C

Registered No. G21996

G21996

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 18
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 831 Boyd St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lowndes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored.	Married

6 (b) Name of husband or wife Luvinia Lowndes
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 6, 1896

8. AGE: Years	Months	Days	If less than one day
48	4	19	hr. min.

9. Birthplace Annarundle Co. Md. (Town, county, and state)
10. Usual Occupation Steamfitter
11. Industry or business

FATHER — 12. Name William Lowndes
13. Birthplace Md

MOTHER — 14. Maiden Name Lillie Hall
15. Birthplace Md.

16 (a) Informant Luvinia Lowndes
(b) Address 831 Boyd St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Braddish Ave
19 OCT 27 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25 19 44, at 8 30 P. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hemorrhage into abdomen; Hemo Thorax, Left;

Due to Compound Fracture of Rib, Left

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 15-7
(a) Date of injury October 23 1944
(b) Where did injury occur? Mondawmin Hill Sta.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work?
(d) Means of injury Auto collision

23. Signature Robert Le Gratam M.D. Medical Examiner.
Date signed 10-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G21997

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

G21997
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3238 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
Over 65			hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business Unk

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof 10/28/44
(Burial, cremation, or removal) (Month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles H. Ward
(b) Address Madison & Pine

19 (a) OCT 27 1944 (b) Thurlington for Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 24 1944, at 9.05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death Cerebral hemorrhage — Duration 6 hrs.
Due to Hypertension
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus M.D.
Address Johns Hopkins Hosp. Date signed 10/25/44

VS 150

For O. H. L. Wollenweber by Howard D. Madison M.D.

G21998

HEALTH DEPARTMENT—CITY OF BALTIMORE

G21998

CERTIFICATE OF DEATH ✓161a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 Andre St 1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 How long in U. S. If of foreign birth? ... yrs. ... mos. ... da.

If U. S. Veteran specify WAR

2. FULL NAME Baby Boy Furman

(a) Residence: No. 1308 Andre St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
M	W	

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) Oct. 26, 1944

7. AGE	Years	Months	Days	If LESS than 1 day... hrs. or... min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto. Md.
(State or country)

FATHER

13. NAME Michael Furman

14. BIRTHPLACE (city or town) Balto.
(State or country) Md.

MOTHER

15. MAIDEN NAME Helen Friedman

16. BIRTHPLACE (city or town) Balto.
(State or country) Md.

17. INFORMANT Helen Furman
(Address) 1308 Andre St.

18. BURIAL, CREMATION, OR REMOVAL

Place ... Date ... 19

19. UNDERTAKER
(Address)

20. OCT 27 1944 Huntington Williams M.D.
Registrar

UNIVERSITY MEDICAL SCHOOL OCT 27 1944
COMMISSIONER OF HEALTH

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Oct. 26, 1944

22. I HEREBY CERTIFY, That I attended deceased from 10-26, 1944 to 10-26, 1944

I last saw him alive on 10-26, 1944 Death is said to have occurred on the date stated above, at 11 A.M.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Atelectasis	10-26-44
Other contributory causes of importance	

Was an operation performed? ... Date of ...

For what disease or injury? ...

Name of operation ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ...
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place ...

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased?
... If so, specify ...

(Signed) A. Bullock M. D.

(Address) 707 E. Fort Ave

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

VS 8

2269

G21999

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G21999 Registered No. 1647

1 6a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard & Green Streets
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 12 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Lodaville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Riggs

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Dr. Augustus Riggs
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1860

8. AGE: Years	Months	Days	If less than one day
84 yrs			hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER
12. Name Dr. Stevens
13. Birthplace New Hampshire

MOTHER
14. Maiden Name Stanfield
15. Birthplace Md.

16 (a) Informant Augustus Riggs
(b) Address Lodaville

17 (a) Burial (b) Date thereof Oct. 30, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Grove Cemetery
Location Glenwood, Md.

18 (a) Funeral director C. Harry Dew
(b) Address Leyhenville, Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.
OCT 30 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27 1944, at 6:20 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/25 1944, to 10/27 1944, and that I last saw her alive on 10/26 1944.

Immediate cause of death Bronchial Pneumonia — Duration
Due to Hypostasis
Due to Fractured Left Hip
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ace.
(b) Date of occurrence 10-15-44 at 5:30 M
(c) Where did injury occur? Lodaville - Md.
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home While at work? no
(Specify type of place)
(e) Means of injury Burns, Car upset + fell.

23. Signature Thos. F. Mosberg Jr.
Address Union Mills, Md. Date signed 10/27/44 M. D.

Hours by Thomas F. Mosberg, M.D.

G22000

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

106 L

G22000

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4502 Hamptett Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4502 Hamptett Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry E. Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Single

6 (b) Name of husband or wife Macie B
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) May 3 1883

8. AGE: Years	Months	Days	If less than one day
61	5	23	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Commission Merchant
11. Industry or business Self

FATHER
12. Name Richard Little
13. Birthplace Virginia

MOTHER
14. Maiden Name Annie Kune
15. Birthplace Maryland

16 (a) Informant Macie Little
(b) Address 4502 Hamptett Ave

17 (a) Burial (b) Date thereof Oct 28 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Morelund
Location Baltimore

18 (a) Funeral director Wm Cook Sons
(b) Address Baltimore Md

19 (a) (b) OCT 27 1944
(Date rec'd by registrar)

Registrar Wilkinson

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1944 at 3:40 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 1943 19 , to Oct 19 44 and that I last saw h alive on 10-25 19 44.

Immediate cause of death Bronchial Stasis — Duration 5 Years

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. W. Peaple M. D.
Address 4508 Harford Rd Date signed 10-26-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Huntington

G22001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1931

G22001

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Lexington St
(c) Hospital or institution:
Lyd Women's and Mens Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary E Whitsell

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1 1863

8. AGE: Years	Months	Days	If less than one day
81	6	25	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert Rogers Anderson
13. Birthplace Charles Co. Md

MOTHER
14. Maiden Name Mary L Gillette
15. Birthplace Ohio

16 (a) Informant Lyd Women and Mens Home
(b) Address 1400 N Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Williams Lodge
(b) Address 1219 E Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

Oct 27 1944
Interment for Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1944 at 1:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16/1930 to 10/26/1944.
and that I last saw her alive on 10/25/ 1944.

Immediate cause of death Myocarditis, chronic. — Duration 1 yrs.

Due to

Due to

Other Conditions Ovarian cyst. — Duration 7 yrs.

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Elbert B Jeffery M. D.
Address 11 E. Chase St., City Date signed 10/26/44

G24002 BALTIMORE CITY HEALTH DEPARTMENT G24002
Registered No.

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 E. York st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1022 Bruce st. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Scandina

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband William Scandina
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 7th 1917

8. AGE: Years	Months	Days	If less than one day
27	8	18	hr. min.

9. Birthplace Va. (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business at Home

FATHER
12. Name Ellis V. Sadler
13. Birthplace Va.

MOTHER
14. Maiden Name Lula Harris
15. Birthplace Va.

16 (a) Informant William Scandina
(b) Address 4 E. York st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Brooklyn A. R. C. Md.

18 (a) Funeral director William Cook Inc.
(b) Address St. Paul st.

19 (a) OCT 27 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from April 5 1944 to Oct 26 1944 and that I last saw h[illegible] alive on Oct 22 1944

Immediate cause of death
Pulmonary Tuberculosis — Duration 6 Mos
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature O. M. Mellits MD
Address 1279 Williams Date signed 10/26/44

Huntington Ave

G2-003

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1461

Registered No. G2-003

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1735 Carswell st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 T
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1735 Carswell St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Philmenia (Lula) Switzer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Edwin L. Switzer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4th 1867

8. AGE: Years	Months	Days	If less than one day
77	6	21	hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name Wm Frederick Lehnhoff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Mary (Unknown)
15. Birthplace Balto. Md.

16 (a) Informant William J. Switzer
(b) Address 1735 Carswell St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 27 1944 (Date rec'd by registrar) Hunting ton Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25th 1944, at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Oct 25 1944
and that I last saw h. alive on Oct 24 1944

Immediate cause of death Carcinomatosis — Duration 6 mo

Due to Carcinoma Stomach — 9 mo

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Fritz G Stringer M.D.
Address 2700 Harford Road Date signed Oct 26 1944
M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS 130

G2:004 GEORGIA Molitor G2:001

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1312

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Oakland & Lanvale Aves
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 527 S. Bentalou st (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Georgia Molitor

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-05-6445

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Peter Molitor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22nd 1918

8. AGE: Years	Months	Days	If less than one day
26	0	4	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Inspector
11. Industry or business Westinghouse Co

FATHER
12. Name George W. Staff
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name May Kradler
15. Birthplace Md.

16 (a) Informant Mrs May W. Staff
(b) Address 527 S. Bentalou St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery ~~crematory~~ Glen Haven
Location Glenburnie Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St.

19 (a) OCT 27 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1944, at 4:45PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 6 1944, to Oct 26 1944, and that I last saw h.s.r. alive on Oct 26 1944

Immediate cause of death Chronic nephritis

Due to

Due to

Other Conditions Suparadetic pleurisy

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Suparadetic pleurisy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Lucile C. Baldwin M. D.
Address West Baltimore General Hos Date signed 10/26/44

G22005

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46b

G22005 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1630 Bolton St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1630 Bolton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Homer Grim

3 (b) If veteran, name war W
3 (c) Social Security Account No. [illegible]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mary T
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 5, 1871

8. AGE: Years	Months	Days	If less than one day
72 74	11	21	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Edward Grim
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emma Murdock
15. Birthplace Balto Md

16 (a) Informant Mary T Grim
(b) Address 1630 Bolton St

17 (a) Funeral (b) Date thereof 11-3-44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Milton Cox
(b) Address 1217 E Fayette St

19 (a) OCT 28 1944 (b) [illegible] Registrar
(Date rec'd by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26-1944 at 9:35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Adeno-carcinoma of Stomach

Due to

Other Conditions Anemia.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Weldon M.D.
Medical Examiner.
Date signed 10-27-44

62-006

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 157e

62-006

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town ~~Baltimore~~ Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 306 Joppa Rd (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Coale

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 26, 1944

8. AGE: Years | Months | Days 1 | If less than one day hr. min.

9. Birthplace University Hospital (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Herbert W. Coale
13. Birthplace

MOTHER
14. Maiden Name Dora Moran
15. Birthplace Maryland

16 (a) Informant Herbert Coale
(b) Address Towson Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-44 (month) (day) (year)
(c) Cemetery or crematory Prospect Hill
Location Towson Md

18 (a) Funeral director Wilson & Son
(b) Address OCT 27 1219 E Fayette St

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1944 at 9:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Oct 27 1944, and that I last saw her alive on Oct 27 1944

Immediate cause of death Respiratory Failure — Duration

Left Pulmonary Atelectasis

Due to Diaphragmatic Hernia & Intestinal resection displaced

Due to

Other Conditions Dextra cardia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: As above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Millard T Galbondy Jr M. D.
Address University Hospital Date signed 10/27/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G28007

~~G28007~~

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2117 Penrose Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2117 Penrose Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Delia Heckett

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Thomas M. Heckett

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12, 1876

8. AGE: Years 68 | Months 6 | Days 14 | If less than one day hr. min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name Thomas Langon
13. Birthplace Ireland

MOTHER
14. Maiden Name Unknown
15. Birthplace Ireland

16 (a) Informant Mrs. Delia Caskey

(b) Address 2117 Penrose Avenue

17 (a) Burial (b) Date thereof 10-30-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Our Cathedral

Location Baltimore, Md.

18 (a) Funeral director Leo. W. Seltzer

(b) Address 2101 Frederick Avenue

19 (a) [illegible] (b) [illegible]
[illegible] Registrar

OCT 27 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1944 at 12 00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to Oct 26 1944, and that I last saw her alive on Oct 26 1944

Immediate cause of death	Duration
Chronic Myocardial Degeneration	2 yrs
Due to	
Due to	
Other Conditions Arteriosclerotic C.V.D.	6 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN.
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chester J. Fabrizio M.D.
Address 2117 Penrose Ave Date signed 10/26/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22008

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

1940 G22008
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: 600 E. Clement St
(c) Hospital or institution: 24

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 600 E. Clement St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mollie Hopf

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband Rudolph

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 18-1877

8. AGE: Years 67 | Months 9 | Days 8 | If less than one day hr. min.

9. Birthplace Balto Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Carl Schaefer
13. Birthplace Germany

MOTHER
14. Maiden Name Mollie Mulfa
15. Birthplace Germany

16 (a) Informant Jennie Lutteke
(b) Address 600 E. Clement St

17 (a) Burial (b) Date thereof 10/1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory London Pk.
Location Front Ave

18 (a) Funeral director Geo Lumpfach
(b) Address 1 W. Lexington St
Huntington Williams, M.D.
(b) (Signature of registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26 1944 at 11:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-20 1944 to 10-26 1944 and that I last saw h[illegible] alive on 10-26 1944

Immediate cause of death: Coronary Thrombosis — Duration: 1 wk.
Due to: Arteriosclerosis — 14 yr.
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature A. Hallock M. D.
Address 207 E. Fort Ave. Date signed 10-27-44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22009

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1370 Registered No. G22009

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: University Hospital, Redwood
(c) Hospital or institution: Y Interne Sts.

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 62 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2106 Boone St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles Hood.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Margaret C. Hood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years	Months	Days	If less than one day
62			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Sales manager.
11. Industry or business

FATHER
12. Name Frank Hood
13. Birthplace

MOTHER
14. Maiden Name Josephine Litard
15. Birthplace

16 (a) Informant Hosp. records.
(b) Address University Hosp.

17 (a) Burial (b) Date thereof 10-28-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Loudon Park

18 (a) Funeral director
(b) Address

(a) Date received (b) Huntington Williams M.D. Registrar
OCT 28 1944

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-25 1944, at 11:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1944, to 10-25 1944, and that I last saw h.i.m alive on 10-25 1944

Immediate cause of death Cardiac failure,

Duration

Due to

Due to

Other Conditions Hypertrophy of prostate. Erosion of Sigmoid
(Include pregnancy within 3 months of death)

Date of operation 10-24-44

Major findings of operation: Enlarged prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Otto R. Ewig M. D.
Address University Hosp. Date signed 10-26-44

G22010

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22010

TN. 90388

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 22-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 819 S. Charles St (If rural give location)
(e) Citizen of foreign country? (Yes) No) If yes, name country

3 (a) FULL NAME Cornelius Coffey

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	Married

6 (b) Name of husband or wife: Kinnie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 22, 1874

8. AGE: Years	Months	Days	If less than one day
69	11	28	hr. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual Occupation: Unemployed
11. Industry or business: Leather

FATHER
12. Name: William Coffey
13. Birthplace: Va.

MOTHER
14. Maiden Name: Smethis Camel
15. Birthplace: Va.

16 (a) Informant: Baltimore City Hospitals
(b) Address: 4940 Eastern Ave (Records

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory: Meadow Mountain
Location: Waynesboro Pa.

18 (a) Funeral director: William Cook Inc
(b) Address: 1217 St. Paul st

(Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26, 1944 19 , at 3.30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25 19 44 to 10-26 19 44, and that I last saw him alive on 10-26 19 44.

Immediate cause of death	Duration
Cachexia	?
Due to Carcinoma of prostate with extensive metastasis	1 yrs
Due to	
Other Conditions Urinary obstruction	5-6 mos

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Harold E. Bolton M.D.
Address Balt City Hosp. Date signed 10/24/44

G22011

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

310

Registered No. G22011

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3148 Remington Avenue
(c) Hospital or institution:

12-7

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3148 Remington Avenue (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Milton Mays

3 (b) If veteran, name war —

3 (c) Social Security Account No. 217-01-1740

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Amelia Schmidt Mays

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 24-1873

8. AGE: Years 71 | Months 7 | Days 1 | If less than one day hr. min.

9. Birthplace Mount Carmel, Maryland (Town, county, and state)

10. Usual Occupation Painter

11. Industry or business

FATHER
12. Name John Mays
13. Birthplace Maryland

MOTHER
14. Maiden Name Stootton
15. Birthplace Maryland

16 (a) Informant Mrs. Thelma Craig
(b) Address 531 E 41st St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 28-1944 (month) (day) (year)

(c) Cemetery or crematory Moreland Memorial Park
Location Baltimore Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3631 Falls Road

19 (a) (b) Huntington Williamsport, Md.

OCT 26 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25- 1944, at 5:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 1942, to Oct 25 1944, and that I last saw h[illegible] alive on Oct 25 1944.

Immediate cause of death Cerebral hemorrhage — Duration ?

Due to Hypertensive cardio-vascular-renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. McTavish Jr. M. D.
Address 1900 N. Charles St. Date signed 10/26/44

G22012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

465 Registered No. G22012

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette & John St
(c) Hospital or institution: Hospital for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 66 days
(e) Length of stay in Baltimore (yrs., mos., or days) 66 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Florida (b) County
(c) City or town Dunedin (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) FULL NAME ELLA KATHERINE CALDWELL
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife R. E. Caldwell
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1868

8. AGE: Years	Months	Days	If less than one day
76	9	13	16 hr. 32 min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Henry Toadvine
13. Birthplace Md

MOTHER
14. Maiden Name Mary —
15. Birthplace Md

16 (a) Informant Women's Hosp Records
(b) Address Lafayette & John Sts

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 29-1944 (month) (day) (year)
(c) Cemetery or crematory Tyaskin
Location Tyaskin, Wicomico Co. Md.

18 (a) Funeral director Dwyer Funeral Home
(b) Address 3631 Falls Road

OCT 28 1944 (Date received by registrar) (b) Huntington Willis Jones M.D.

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 1944, at 4:32 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 22 1944, to Oct. 27 1944, and that I last saw h[illegible] alive on Oct. 27 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Carcinoma of stomach	
Other Conditions Cystitis, Cholelithiasis, Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: To be reported

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. D. Speed III M. D.
Address Women's Hospital Date signed 10-29-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22013

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1248

G22013 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Sq. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 900 N. Bond St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Charles Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1889

8. AGE: Years 55 | Months 3 | Days 12 | Or if less than one day hr. min.

9. Birthplace Towson, Balto Co, Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER: 12. Name Emanuel Mock
13. Birthplace Md.

MOTHER: 14. Maiden Name Lizzy Lyttle
15. Birthplace Md.

16 (a) Informant Charles Williams
(b) Address 900 N. Bond

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29th 1944 (month) (day) (year)
(c) Cemetery or crematory Pleasant Rest
Location Towson, Balto Co. Md.

18 (a) Funeral director Belmont Mamie McWright
(b) Address 721 Aisquith St.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS OCT 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 25 1944, at 6 32 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10 10 1944 to 10 25 1944 and that I last saw h.e alive on 10 25 1944

Immediate cause of death: (a) Exfoliative dermatitis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy Ex. dermatitis Liver cirrhosis

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 10/28/44 M D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Correct age is especially important.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Be sure that correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22014

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22014
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5200 St. George Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 709 Light St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM AUBREY POMEROY

3 (b) If veteran, name war: World War #1

3 (c) Social Security Account No. --

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Divorced

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/25/1882

8. AGE: Years 61 | Months 10 | Days 2 | If less than one day hr. min.

9. Birthplace St. Mary's Co., Md.
(Town, county, and state)

10. Usual Occupation None - Veteran

11. Industry or business World War #1

FATHER
12. Name Charles H. Pomeroy
13. Birthplace Va.

MOTHER
14. Maiden Name Ruth V. Clements
15. Birthplace Md.

16 (a) Informant Mr. Cecil A. Pomeroy
(b) Address 1224 N. Decker Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

OCT 28 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Oct 1944, at 12:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 20 Oct 1944, to 27 Oct 1944, and that I last saw him alive on 27 Oct 1944

Immediate cause of death: Bronchial asthma — Duration 5 yrs

Due to: Fungus abscess Intestinal - — Duration 25 yrs

Due to: Gas Poisoning - World War I. —

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide X
(b) Date of occurrence X at M
(c) Where did injury occur? X (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? X While at work? X
(Specify type of place)
(e) Means of injury

23. Signature Wayne Hooper

Address 33-34 Glenside Date signed 10-30-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22015

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D Registered No. G22015

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2127 Chelsea Terr.
(c) Hospital or institution:
15-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 Chelsea Terr. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: WILLIAM HUNTER TARR

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Beatrice E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 4, 1882

8. AGE: Years	Months	Days	If less than one day
62	6	22	hr. min.

9. Birthplace: Wallsburg, W. Va. (Town, county, and state)
10. Usual Occupation: Clerk
11. Industry or business: B. & O. R. R.

FATHER
12. Name: Clarence Tarr
13. Birthplace: Wallsburg, W. Va.

MOTHER
14. Maiden Name: Sarah Johnson Robson Reynolds
15. Birthplace: Steubenville, Ohio

16 (a) Informant: Mrs. Beatrice E. Tarr
(b) Address: 2127 Chelsea Terr.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 28 1944 (Date received by registrar) (b) Huntington Williams, M.D. Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26, 1944 at 10:00 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 18 1944 to Oct 26 1944 and that I last saw him alive on Oct 26 1944

Immediate cause of death: Arteriosclerotic Heart Disease — Duration: 10 years
Due to: Generalized Arteriosclerosis
Due to:
Other Conditions: Hypertension — Duration: 5 Days
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

M. D. Signature: Robert J. Shochat
Address: 2302 Edmondson Ave Date signed 10/28/44

Shochat

G22016

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22016 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5206 Plainfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5206 Plainfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret D. Gilka (or) Dominica M. Gilka

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-20-4494

4. Sex: F. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8 - 1916

8. AGE: Years 28 | Months 4 | Days 18 | If less than one day hr. min.

9. Birthplace Balto County (Town, county, and state)

10. Usual Occupation Office Clerk

11. Industry or business Martin Aircraft

FATHER
12. Name Frank J. Gilka
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Smelzer
15. Birthplace Balto

16 (a) Informant Frank J. Gilka
(b) Address 5206 Plainfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director W. W. E. Dipp & Sons
(b) Address 7110 Belair Rd.

19 (a) (b)

OCT 28 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1944 at 12:18 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 17 1944 to Oct 26 1944, and that I last saw her alive on Oct 26 1944

	Duration
Immediate cause of death: Cardio Respiratory paralysis possible cerebral metastases	
Due to: General Carcinomatosis abdominal	1 year
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation Dec 28 1943

Major findings of operation: carcinoma advanced, lower abdomen

of autopsy? Palvers

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. V. Clift M. D.
Address 5010 Greenleaf Rd Date signed 10-27-44

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22017

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 59

Registered No. G22017

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: W. B. D. H.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 da
(e) Length of stay in Baltimore (yrs., mos., or days) 4 da

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Balt Sparrows Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1428 Shore Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Lohman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-22-'44

8. AGE: Years	Months	Days	If less than one day
		4	hr. min.

9. Birthplace W. B. D. H.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Charles Henry Lohman
13. Birthplace N. Y. C. N. Y.

MOTHER
14. Maiden Name Margaret Rockbrook
15. Birthplace Fillmore, N. Y.

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL OCT 28 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 OCT 28 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1944, at 2 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22 1944 to 10-26 1944, and that I last saw him alive on 10-26 1944.

Immediate cause of death Respiratory Failure — Duration

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward C. Day M. D.
Address West Balto Gen. Hosp. signed 10/26/44

VS 280

2270

G22018

AB-90335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1519

G22018

Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 4802 E. Hoffman St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John Thomas Burgess

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept-16-1944

8. AGE: Years | Months: 1 | Days: 11 | If less than one day: hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Russell Burgess

13. Birthplace Md.

MOTHER

14. Maiden Name Goldie James

15. Birthplace Va.

16 (a) Informant Baltimore City Hospitals (Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28/44 (month) (day) (year)

(c) Cemetery or crematory H. Mays

Location Hampden

18 (a) Funeral director Lohmeyer & Donovan

(b) Address 2616-18 Chestnut Ave

19 (a) Oct 28 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1944, at 6.55 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22- 1944 to 10-27- 1944, and that I last saw him alive on 10-27- 1944

	Duration
Immediate cause of death: Pneumonia & respiratory failure	12 hours
Due to: Postoperative Atelectasis	
Due to: Pyloric stenosis	2 weeks
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-26-44

Major findings of operation: Pylorus Serosa

of autopsy: Lobar pneumonia, both

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ellis Feer M. D.

Address Baltimore City Hosp. Date signed 10-27-44

G22019

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

17 1A G22019 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital 13-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 hrs +
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1365 Weldon Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John C. Somerville

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Ella Somerville

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1875

8. AGE: Years 69 | Months 7 | Days 2 | If less than one day hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John Somerville
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant John A. Somerville
(b) Address 3960 Falls Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Road.

18 (a) Funeral director Clemmer & Donovan
(b) Address 3615-17 Eastern Ave

19 (a) OCT 28 1944 (b) Registrar.
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1944, at 5:05 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Fractured Skull

Due to

Other Conditions Other fractures, lacerations, bruises etc.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-26- at 25-4 11.48 P.M.
(b) Where did injury occur? Patapsco Ave & 6th St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Struck by street car

23. Signature Howard J. Waldeis M.D.
Medical Examiner.
Date signed 10-27-44

G220.c0

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

137a G220.c0 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct ago is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Greene & Lombard Sts
(c) Hospital or institution: University Hospital, Balt, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 45 days
(e) Length of stay in Baltimore (yrs., mos., or days) 45 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Westminster (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Ezra Fairell

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 3, 1857

8. AGE: Years 87 | Months 7 | Days 22 | If less than one day hr. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)

10. Usual Occupation Miller

11. Industry or business Own Mill.

FATHER
12. Name William Fair
13. Birthplace Penna.

MOTHER
14. Maiden Name Magdelia Merckle
15. Birthplace Penna.

16 (a) Informant Records. Carroll Co., Home
(b) Address Westminster, Md.

17 (a) Burial. (Burial, cremation, or removal) (b) Date thereof Oct. 28, 1944 (month) (day) (year)
(c) Cemetery ~~crematory~~ St. Peters.
Location Baltimore Co., Md.

18 (a) Funeral director Jacob Hartenstein
(b) Address Mt. Freedom, Pa.

19 (a) (Registrar's signature) (b) Registrar

OCT 28 1944 Huntington Millards, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26 1944, at 9451 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 1944 to Oct 26 1944 and that I last saw him alive on Oct 26 1944

Immediate cause of death Uremia — Duration 2 yrs
poisoning.
Due to Ureteral obstruction
Due to
Other Conditions None
(Include pregnancy within 3 months of death)

Date of operation 10/12/44
Major findings of operation: Benign prostatic hypertrophy
of autopsy: ureteral obstruction.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles D. Claffet M.D.
Address University Hospital Date signed 10/26/44

G22021

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1932

Registered No. G22021

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 616 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 616 N. Fulton Avenue (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. Kilpatrick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Annie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1878

8. AGE: Years	Months	Days	If less than one day
66	5		hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name Edward J.

13. Birthplace Georgia

MOTHER 14. Maiden Name Mahie Scott

15. Birthplace Georgia

16 (a) Informant Edward J. Kilpatrick, Jr.

(b) Address 616 N. Fulton Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-25-44 (month) (day) (year)

(c) Cemetery or crematory

Location Canton Cemetery

18 (a) Funeral director George A. Ehrling

(b) Address Fulton & Fayette

OCT 28 1944 (Date rec'd by registrar) Hunting for Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1944, at 3:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature W. E. Wallenmeyer M.D.
Medical Examiner.

Date signed Oct. 28, 1944

VS 151

MJ-54635 8-18

G22022

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161 C

Registered No. G22022

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 21 days
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3 ½ mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 919 Lenox St (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Lois Butler.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8 1944

8. AGE: Years | Months 3½ | Days 17 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)

10. Usual Occupation
11. Industry or business

FATHER — 12. Name Quentin W. Butler
13. Birthplace —

MOTHER — 14. Maiden Name Blair
15. Birthplace —

16 (a) Informant Hosp Record
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem. Co. - Md
Location

18 (a) Funeral director Thos. Peter R. Williams
(b) Address 3224 Sebastian St

19 OCT 28 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1944, at 3P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 4 1944 to Oct 25 1944 and that I last saw h[illegible] alive on Oct 25 1944

Immediate cause of death Coma Shock. — Duration Life

Due to Coma, Abortus ? bile Peritonitis.

Due to also Anuria

Other Conditions of gall bladder. Chronic Colitis

(Include pregnancy within 3 months of death)

Date of operation Oct 24

Major findings of operation: Abscess

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Special type of place) While at work?
(e) Means of injury

23. Signature J. Welch M.D.
Address Normandy Date signed 10-25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful[ly] supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22023 — BALTIMORE CITY HEALTH DEPARTMENT — G22023

CERTIFICATE OF DEATH 166

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Comdent Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 da
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town (If outside city or town limits, write R.F.D. and give town)
(d) Street No. 1339 Stockton St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIS MONTGOMERY

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: M
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: M
6 (b) Name of husband or wife: Genevieve
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July - 1906

8. AGE: Years 38 | Months 3 | Days | If less than one day hr. min.

9. Birthplace Columbia - D.C. (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business

FATHER
12. Name Willis Montgomery
13. Birthplace Hunter - D.C.

MOTHER
14. Maiden Name Gertrude Cannon
15. Birthplace Newberry - D.C.

16 (a) Informant Mrs.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 28, 1947 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St.

19 (Signature of registrar) Huntington Williams, M.D. Registrar
OCT 29 1947 (Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1947 at 12.40 M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Bullet wound of head

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 21, 1947 at 4:45 P. M.
(b) Where did injury occur? 1200 block N. Fremont Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Shot with pistol.

23. Signature H. L. Wallenstein M.D. Asst Medical Examiner.
Date signed 10-22-47

M.A. Exam. Case

G22024

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

Registered No. G22024

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 14
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1514 Pe- Ave (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Frederick Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 19 - 1921

8. AGE: Years 43 | Months 8 | Days 4 | If less than one day ..... hr. ..... min.

9. Birthplace Woodstock - Howard Co. Md
(Town, county, and state)

10. Usual Occupation .....
11. Industry or business .....

FATHER
12. Name Frederick Smith
13. Birthplace Howard Co - Md.

MOTHER
14. Maiden Name Bronie Hall
15. Birthplace Howard Co. - Md.

16 (a) Informant Mrs. Annie Smith
(b) Address [illegible]

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Balto. Co. - Md.

18 (a) Funeral director Mr Katie R. Williams
(b) Address 322 N. Schroeder St

19 (a) OCT 28 1944 [illegible] for Williams Mort
(Registrar's signature) For R. J. Lubinski, by Howard J. Andersen, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct - 23 1944 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...,
and that I last saw h..... alive on ..... 19....

Immediate cause of death	Duration
unknown	
Due to cardiac failure	
Due to Pyelitis urethrovesical	
Other Conditions 2 Rheumatic heart disease	
2 Arteriosclerosis (within 3 months of death)	

Date of operation.....
Major findings of operation:.....
.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....

23. Signature Abraham Aeneas M. D.
Address Johns Hopkins Hosp Date signed 10-24-44

G22025

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22025

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Date of birth of deceased if under one year is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 E. Preston St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 E. Preston St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Perry

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex F. | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-26-1944

8. AGE: Years | Months | Days 1 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER 12. Name Warren Perry
13. Birthplace Va

MOTHER 14. Maiden Name Virginia Sharp
15. Birthplace Va

16 (a) Informant Warren Perry
(b) Address 1706 E. Preston St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. L. Co

18 (a) Funeral director Rayner Sanders
(b) Address 1412 E. Preston St

19 (a) OCT 28 1944 (Must not be left blank) Huntington Williams, M.D. Address

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1944 at 11 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Oct 27 1944 and that I last saw her alive on Oct 26 1944.

Immediate cause of death	Duration
Premature.	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mervis G. Fine M.D.
Address 1 E Biddle St Date signed 10/27/44

~~W-22026~~ Krvelle 93B G22026

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lombard + Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits write RURAL and give town)
(d) Street No. 4515 Hampnethline. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frederick C. Kruelle

3 (b) If veteran, name war —

3 (c) Social Security Account No. 212-20-2442

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife Emma E.

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Mar 15, 1871

8. AGE: Years 73 | Months 7 | Days 10 | If less than one day ... hr. ... min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Hany Kruelle
13. Birthplace Germany

MOTHER
14. Maiden Name ? Kaufmann
15. Birthplace Germany

16 (a) Informant Carl H. Kruelle
(b) Address 535 Stannard Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/28/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Gitzdon Lane

18 (a) Funeral director J. Heeman & Son
(b) Address 32 S Broadway

19 (a) (Date received by Local Registrar) OCT 28 1944 (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/25 1944, at 9 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 1944, to 10-25 1944, and that I last saw h. alive on 10-25 1944.

Immediate cause of death Pulmonary edema — Duration 4 days

Due to Myocardial degeneration

Due to Arteriosclerotic heart disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen A. Hare M. D.
Address Maternity Hosp Date signed 10/26/44

~~Dr. Silvio Alessi~~
Dr. Edward J. Alessi

BALTIMORE CITY HEALTH DEPARTMENT 93B

CERTIFICATE OF DEATH

Registered No. G22027

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3125 Clearview Avenue
(c) Hospital or institution: 27-5
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore #14
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3125 Clearview Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HUGO HERMAN ZERENNER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Lucy J. Zerenner
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct. 14, 1880

8. AGE: Years	Months	Days	If less than one day
64	--	13	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Restaurant Owner
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Lucy J. Zerenner
(b) Address 3125 Clearview Avenue #14

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

OCT 28 1944 (b) Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1944, to Oct 27 1944, and that I last saw h. alive on Oct 27 19 44

Immediate cause of death: Arteriosclerotic Heart disease — Duration: 3 yrs 4 days
Pulmonary Edema
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]
Address 6217 Harford Rd Date signed 10/27/44
M. D.

DAVIS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22028 / 137a

Registered No. G22028

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1600 Caroline Street
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1631 E. Fairmount Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Herbert A. Davis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Ellen Davis

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-16-69

8. AGE: Years	Months	Days	If less than one day
75	2	10	hr. min.

9. Birthplace Newburyport, Mass.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Switch Bd operator

FATHER
12. Name Frank A. Davis
13. Birthplace Mass

MOTHER
14. Maiden Name Emma A. ✓
15. Birthplace Mass

16 (a) Informant Herbert B. Davis
(b) Address 202 Willow Ave. Towson

17 (a) Burial (b) Date thereof 10-30-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory
Location Mallya. Mass

18 (a) Funeral director Lemmon J. Cook
(b) Address 530 E Harford Road

OCT 28 1944 (b) Huntington Williams M.D.
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 26 19 44 at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 29 19 44, to Oct 26 19 44, and that I last saw h.im alive on Oct 26, 19 44.

Immediate cause of death	Duration
(a) Respiratory Cardiac Failure.	5 days
Terminal Bronchopneumonia. Hernia	
Due to (b) Ca. of Prostate Prostatectomy for Ca. of Hypertrophy	
Due to (c) Senility	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-13-44 & 10-24-44

Major findings of operation: Hypertrophied prostate

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert B. McFadden M. D.
Address St Joseph's Hosp. Date signed 10/26/44

G22029

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22029 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Bayside Drive (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Bay Ehinger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: m | 5. Color or race: w | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct, 26, 1944

8. AGE: Years | Months | Days | If less than one day: 4 hr. 25 min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Albert Ehinger
13. Birthplace Swathmore Pa.

MOTHER
14. Maiden Name Henrietta May Morrison
15. Birthplace Swathmore Pa

16 (a) Informant W = Albert Ehinger
(b) Address 2 Bayside Drive

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-28-44 (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Balto. Md

18 (a) Funeral director Henry L. Welton
(b) Address 410 Edmondson Ave.

19 (a) Huntington Williams, Registrar (Date rec'd by registrar)

VS 16a

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26, 1944 at 11-15 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1944 to 10-26 1944 and that I last saw him alive on 10-26 1944

Immediate cause of death: Atelectasis — Duration

Due to: premature birth.

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address South Balt. Gen. Hosp Date signed 10-27-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22030

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G22030
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3312 Liberty Hgts. Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 5/12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3312 Liberty Hgts. Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or ~~No~~)
If yes, name country

3 (a) FULL NAME CATHERINE CLARKE HORN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Francis Horn, Sr.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 31, 1858

8. AGE: Years 86 | Months 4 | Days 26 | If less than one day: hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: Robert A. Clarke
13. Birthplace: Balto.

MOTHER
14. Maiden Name: Unknown
15. Birthplace: "

16 (a) Informant: Mr. Francis Horn
(b) Address: 101 W. Monument Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) Oct 29 1944 (registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1944 at 5:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 23 - 1944, to Oct 27 - 1944 and that I last saw h[illegible] alive on Oct 26 1944.

Immediate cause of death: Cerebral embolism — Duration: 10 days
Due to: Chr. myocarditis — Duration: 2 yrs
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Chas. J. Keller M. D.
Address 222 N. Monument St. Date signed 10/29/44

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22031

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G22031
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital - D.O.A
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lord Baltimore Hotel
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alva Robert Kelso

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Lenora A. Cacchillo
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1909

8. AGE: Years	Months	Days	If less than one day
34	11	20	hr. min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)
10. Usual Occupation Watch Maker
11. Industry or business Self

FATHER
12. Name Charles E. Kelso
13. Birthplace Pittsburgh, Pa.

MOTHER
14. Maiden Name Eleanor Kincaid
15. Birthplace Missouri

16 (a) Informant Miss Verna Hart
(b) Address 5018 Dermore Ave.

17 (a) Burial (b) Date thereof 10/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

OCT 29 1944 (Date Received by Registrar) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1944, at 6:50 P M

21. I certify that I took charge of the remains described above, held an Inspection - Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquest)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Cerebral Hemorrhage due to Hypertensive Cardiovascular
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury —

23. Signature Charles J. Gallagher M.D.
Medical Examiner.
Date signed 10/26/44

G22032

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 77 C

G22032

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto 25 Md
(b) Street address 3420 Childs Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 3 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town 1010 Clark St
(If outside city or town limits, write RURAL and give town)
(d) Street No. Sparrows Point Md
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Richard E. May

3 (b) If veteran, name war —

3 (c) Social Security Account No. 234-05-5382

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. divorced

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1897

8. AGE: Years 47 | Months 3 1 | Days 8 | If less than one day hr. min.

9. Birthplace Cerado R.F.D. #1 Wayne Co. W.Va.
(Town, county, and state)

10. Usual Occupation Ship Builder

11. Industry or business Sparrows Point Md

FATHER
12. Name John May
13. Birthplace Wayne Co W. Va.

MOTHER
14. Maiden Name Fannie Dillon
15. Birthplace * W.Va

16 (a) Informant Mr Harry Wade
(b) Address 3424 Chesells Court

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-44 (month) (day) (year)

(c) Cemetery or crematory May Cemetery
Location Wayne Co - W. Va.

18 (a) Funeral director Milton Schillaci
(b) Address 3914 S Hanover St

19 (a) (Date rec'd by registrar) Huntington Williamson M.D. (Signature)

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28-44, at 8 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1944 to Oct 28 1944 and that I last saw him alive on Oct 27 1944

Immediate cause of death: Cardiac Insufficiency — Duration 1 day

Due to: Acute Alcoholism — Duration 2 days

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leon D. Hobbs M. D.

Address 720 Pennington Date signed 10-28-44

G22033

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G22033

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write clearly and legibly. The causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 507 Ensor St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Clinton Foulkes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-18-98

8. AGE: Years	Months	Days	If less than one day
45 46	11	7	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Faulkes
13. Birthplace ?

MOTHER
14. Maiden Name Fannie ?
15. Birthplace ?

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/29/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County, Md.

18 (a) Funeral director Joseph B. Locke, Jr.
(b) Address 1330 N. Central Ave

OCT 29 1944 (Date received by Registrar) (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 25 1944 at 5:22 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 18 1944 to Oct 25 1944 and that I last saw him alive on Oct. 20 1944

Immediate cause of death	Duration
Rheumatic Heart Disease with infarcts to the Lungs	
Due to Mitral stenosis	
Due to Thrombophlebitis Left Leg	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Rheumatic heart dis.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 10/29/44 M. D.

G22034 Parham G22034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183A

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1425 Myrtle Ave
(c) Hospital or institution: 1st
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL, and give town)
(d) Street No. 1425 Myrtle Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Parham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lethi

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) — — 1866

8. AGE: Years 78 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Sussex Co Va
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Robert Parham
13. Birthplace Va

MOTHER 14. Maiden Name Louise ?
15. Birthplace Va

16 (a) Informant Prince Parham
(b) Address 650 N. 47 St Phila Pa

17 (a) Burial (b) Date thereof 10-30-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore Md

18 (a) Funeral director William A Jackson

(b) Address 916 Pennsylvania ave

19 (Date rec'd by Registrar) OCT 29 1944 Hunter Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1944, at 5 P. M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Cerebral hemorrhage

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature D. L. Wollenweber M.D.
Medical Examiner.
Date signed October 28, 1944.

G22035

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22035
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4238 Parkheights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4238 Park Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen DeBaer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May, 19, 1866

8. AGE: Years 78 | Months 5 | Days 4 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business Gift Shop

FATHER
12. Name Jacob De Baer
13. Birthplace Holland

MOTHER
14. Maiden Name Emma Cohen
15. Birthplace Germany

16 (a) Informant Mrs Hannah Blum
(b) Address 4238 Park Heights Ave

17 (a) Burial (b) Date thereof Oct, 29, 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hebrew Friendship Cem
Location E. Baltimore St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (a) 29 1944 (b) Washington Millinery
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27. 1944 at 1230 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1942 to Oct 27 1944
and that I last saw her alive on Oct. 25 1944

Immediate cause of death: Coronary Thrombosis — Duration: Fast
Due to: Arteriosclerosis — Duration:
Due to: — Duration:
Other conditions: Chronic Cholecystitis — Duration: 25 yrs

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature James S Adelsheimer M. D.
Address 1612 Park Ave Date signed 10-27-44

G22036 BALTIMORE CITY HEALTH DEPARTMENT G22036

CERTIFICATE OF DEATH

Registered No.

MARK RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: President Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town write RURAL and give town)
(d) Street No. 706 Gold St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Eva Wiggins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 56 | Months | Days | If less than one day hr. min.

9. Birthplace Lancaster Co Va (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas H. Wiggins
13. Birthplace Lancaster Co Va

MOTHER
14. Maiden Name Hannah Ball
15. Birthplace Lancaster Co. Va

16 (a) Informant Effie Young (sister)
(b) Address 706 Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 30-1944 (month) (day) (year)
(c) Cemetery or crematory Church Cemetery
Location Severn Virginia

18 (a) Funeral director Va Brooks
(b) Address 1463 N. Carey St.

19 (a) OCT 29 1944 (b) Huntingtown Williams, M.D. Address

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1944, at 1 45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 7 1944 to Oct 27 1944, and that I last saw h[illegible] alive on Oct 27 1944.

Immediate cause of death: Carcinoma of the lung and Liver — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: ca of lungs, liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G G Mayfield, M.D. Address President Hospital Date signed 10/30/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

G22037

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

930

Registered No. G22037

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 339 S. CHESTER ST.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 65 YRS.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 339 S. CHESTER ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARTIN W. GLENN

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	WIDOWER

6 (b) Name of husband or wife: ELLEN GLENN
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) NOV. 1 1858

8. AGE: Years	Months	Days	If less than one day
85	11	25	hr. min.

9. Birthplace IRELAND (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name BRYAN GLENN
13. Birthplace IRELAND

MOTHER
14. Maiden Name ANNA FOLEY
15. Birthplace IRELAND

16 (a) Informant HELEN GLENN (DAUGHTER)
(b) Address 339 S. CHESTER ST.

17 (a) BURIAL (b) Date thereof OCT. 30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory NEW CATHEDRAL
Location OLD FREDERICK ROAD

18 (a) Funeral director Lilly and Geiler INC.
(b) Address 403 S. WOLFE ST.

19 (a) 10/29/1944 Huntington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 26 1944, at 2 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 21 1944, to Oct. 26 1944, and that I last saw him alive on Oct. 26 1944.

Immediate cause of death: CORONARY OCCLUSION — Duration 10/26/44

Due to: ARTERIOSCLEROTIC HYPERTENSIVE — Duration ?

Due to: CARDIO-VASCULAR DISEASE

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operations: —
of autopsy: NONE PERFORMED

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Joseph F. Delaney M.D.
Address 209 W. Chester St Date signed 10/27/44

G22038 BALTIMORE CITY HEALTH DEPARTMENT G22038

CERTIFICATE OF DEATH 1931

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 519 S.BELNORD AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S.BELNORD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME GEORGE W.MENZEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY MENZEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG.2 1862

8. AGE: Years	Months	Days	If less than one day
82	2	25	hr. min.

9. Birthplace BALTIMORE MD. (Town, county, and state)
10. Usual Occupation RETIRED
11. Industry or business

FATHER
12. Name UNKNOWN
13. Birthplace BALTO.MD.

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace BALTO.MD.

16 (a) Informant MARY MENZEL (WIFE)
(b) Address 519 S.BELNORD AVE.

17 (a) BURIAL (b) Date thereof OCT.30/44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory PARKWOOD
Location TAYLOR AVE.

18 (a) Funeral director Lilly and Zeiler INC.
(b) Address 403 S.WOLFE ST.

29 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT.27 1944 at 10 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Sept 1944 to Oct 27 1944 and that I last saw h[illegible] alive on Oct 20 1944

Immediate cause of death: Thrombosis of Heart Disease
Due to Coronary occlusion
Other Conditions Ventricular Fibrillation
(Include pregnancy within 3 months of death)

Duration 2 days

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address 400 Medical (Date signed) Oct 27-44

OK JM

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The cause is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G22039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

54B

G22039 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1708 Eutaw Place
(c) Hospital or institution: Fernhurst Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 512 Park ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Clara Miller

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/7/1889

8. AGE: Years 55 | Months 2 | Days 20 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation N Duty

11. Industry or business

FATHER
12. Name Theo Miller
13. Birthplace Unknown

MOTHER
14. Maiden Name Barbara Beck
15. Birthplace Unknown

16 (a) Informant Hosp Records
(b) Address 1708 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Laurel Grove
Location Baltimore Co Md

18 (a) Funeral director J. Fahey Jones
(b) Address 1028 Light St

OCT 29 1944 (Date rec'd by Registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27 - 1944, at 2.45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 26 1944, to Oct. 27 - 1944, and that I last saw her alive on Oct. 27 - 1944.

Immediate cause of death: Cerebral Hemorrhage — Duration

Due to: Metastasis

Due to: Carcinomatosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Louis Jacob M. D.
Address 1700 Eutaw Pl. Date signed Oct. 27-44

G22040

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1930

G22040
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4607 Edmondson ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) 75 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4607 Edmondson ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Lewis Wells

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Martha E. Kugler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 27, 1863

8. AGE: Years: 80 | Months: 0 | Days: 0 | If less than one day: hr. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual Occupation Retired Engineer

11. Industry or business B. & O. R.R.

FATHER: 12. Name Nicholas B. Wells.
13. Birthplace Maryland

MOTHER: 14. Maiden Name Laura J. Berry
15. Birthplace Virginia

16 (a) Informant Mrs. Martha E. Wells
(b) Address 4607 Edmondson Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.30.44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Woodlawn Md

18 (a) Funeral director Harry A. Wilke
(b) Address 4101 Edmondson Ave.

OCT 29 1944 Huntington Williams, Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1944 at 12 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 27 1944, and that I last saw him alive on Oct 24 1944

Immediate cause of death: Cardiac Failure — Duration: 1 month

Due to Myocardial Insufficiency — Duration: ?

Due to Chronic Hypertensive cardio Vascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Walter E. Dampf M. D.
Address 101 Poplar Grove Date signed 10/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The age is especially important. Physicians: please write the causes of death clearly and legibly.

G22041

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

G22041
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 108 S. Willard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 0
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 108 S. Willard St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frieda Foell

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: G. Frederick Foell
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) July 31, 1872
8. AGE: Years 72 Months 2 Days 27 If less than one day hr. min.
9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name — Barth
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant G. Frederick Foell
(b) Address 108 S. Willard St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10.30.44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Writzke
(b) Address 4101 Edmondson Ave.

OCT 29 1944 (b) Huntington Williams, M.D.
(Date received) (Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1944 at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1944 to Oct 27 1944 and that I last saw h.r alive on Oct 27 1944

Immediate cause of death: Congestive Heart Failure — Duration 1 wk
Due to Arteriosclerotic heart disease
Due to
Other Conditions Pernicious anemia ?
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. M. Cullen M. D.
Address 332 Frederick Ave Date signed 10-28-44

VS 159

G22012

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G22012 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 815 W. Mulberry
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 815 W. Mulberry Apt (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Walker

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Bessie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 22 1889

8. AGE: Years 54 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Nelson County Va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER 12. Name Frank Walker
13. Birthplace Va.

MOTHER 14. Maiden Name Henrietta
15. Birthplace Va

16 (a) Informant Bessie Walker
(b) Address 815 W Mulberry

17 (a) Burial (b) Date thereof 10-5-44 (Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial
Location Baltimore County

18 (a) Funeral director Isaiah L. Burnett Son
(b) Address 108 W Monument St

19 (a) Filed by registrar OCT 29 1944 (b) Registrar Huntington Williams, M.D.
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/44 19 , at 3P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 1944 to 10/26 1944
and that I last saw h alive on 10/26 1944

Immediate cause of death Pulmonary Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Evan H. Calhoun

Address 60 W. Mt. Royal Ave Date signed 10/28/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

G22043 ✓ G22043 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1815 N. Gay St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1815 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ella N. Healy.

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 14th 1874

8. AGE: Years	Months	Days	If less than one day
69	10	12	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name John Healy
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Jennings
15. Birthplace Md

16 (a) Informant Mr Groggan
(b) Address 1815 N Gay St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Edmondson Ave

18 (a) Funeral director Leo L. Cook
(b) Address 1701-03 N. Patterson Park Ave

19 (a) Oct 29 1944 (Date received by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26th 1944, at 10 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1944, to Oct 26 1944, and that I last saw h[illegible] alive on Oct 25 1944.

Immediate cause of death	Duration
Cerebral Arteriosclerosis	
Due to	
Due to	
Other Conditions Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Carol Fisher M. D.
Address 803 N. Wood St. Date signed 10/27/44

MARK "X" IN RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22044

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 177

G22044 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 544 N. Lanvale St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 544 N. Lanvale St (If no street, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Arnold L. Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/20/1917

8. AGE: Years 29 | Months 10 | Days 7 | If less than one day: hr. min.

9. Birthplace Syracuse, N. Y. (town, county, and state)

10. Usual Occupation Musician

11. Industry or business

FATHER
12. Name George Thomas
13. Birthplace Albany, Ohio

MOTHER
14. Maiden Name Mary Finley
15. Birthplace Portland, Maine

16 (a) Informant Mrs. Alice Pixley
(b) Address 510 E. 147th St. N. Y.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 29 1944 (month) (day) (year)

(c) Cemetery or crematory Woodlawn, N. Y.
Location New York, N. Y.

18 (a) Funeral director Wm. Lange 2 E. Highland
(b) Address 1651 Madison Ave

19 (a) Huntington Williams, M.D. Registrar (b) (Date received by registrar)

OCT 29 1944 VS FW

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1944, at 6:54 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Oct 27 1944 and that I last saw him alive on Oct 27 1944.

Immediate cause of death Stomach
Poison
Due to Infection
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)

Duration
over

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Thos L Hamblen M. D.
Address 212 Med Sch Date signed 10-27-44

G22045

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G22045
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1407 Madison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md., (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1407 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Wm Bradley

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sophia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 15, 1880

8. AGE: Years 64 | Months 2 | Days 11 | If less than one day hr. min.

9. Birthplace Kent Island, Md.
(Town, county, and state)

10. Usual Occupation Fireman (Engineer)

11. Industry or business

FATHER — 12. Name Unknown
13. Birthplace

MOTHER — 14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Sophia Bradley
(b) Address 1409 Madison Ave.

17 (a) Burial (b) Date thereof Oct 29 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Arbutus Mem. Pk.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lacy M. Holland
(b) Address 1601 David Hill Ave.

OCT 29 1944 (a) (b) Huntington Williams, M.D.
(Date rec'd by City Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26 1944, at 12 H M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1944 to 10/26 1944, and that I last saw alive on 10/25 1944

Immediate cause of death Coma Pneumonia

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Burke Butler M. D.
Address 329 Date signed 10/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BU...ING

G22046 ✓ G22046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4010 Alto Rd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4010 Alto Rd.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELIZABETH JANE GAITHER SUMMERS

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Charles D. Summers
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 4, 1865

8. AGE: Years: 79 | Months: 5 | Days: 23 | If less than one day: hr. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Vachel H. Gaither
13. Birthplace: A. A. Co.

MOTHER
14. Maiden Name: Margaret Robinson
15. Birthplace: A. A. Co.

16 (a) Informant: Mr. Charles D. Summers
(b) Address: 4010 Alto Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory: Towson Park Cem.
Location: Balto., Md.

18 (a) Funeral director: Wm. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) OCT 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1944, at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1944, to Oct 27 1944, and that I last saw h-r alive on Oct 26 1944.

Immediate cause of death	Duration
Chr. myocarditis	
Due to	
Due to	
Other Conditions Chr. Myocarditis	

(Include pregnancy within 3 months of death)

Date of operation none

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George E. Shannon M.D.
Address 720 Medical Arts Bldg. Date signed 10/28/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARG... RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22047

JL - 90323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 930

G22047 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 days
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1521 Park Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Frances Niner

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widowed

6 (b) Name of husband or wife Charles E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 30, 1868

8. AGE: Years	Months	Days	If less than one day
76	2	28	hr. min.

9. Birthplace ~~NEW~~ New Orleans, La.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business E.

FATHER
12. Name Charles Rockwell
13. Birthplace ? La.

MOTHER
14. Maiden Name Frances ? E.DeMarguenier
15. Birthplace La.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)
(c) Cemetery or crematory Loudon
Location Frederick Rd.

18 (a) Funeral director Wm. J. Tickner & Sons
(b) Address North & Pa. Aves.

19 29 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28-44 1944, at 4.15 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-21 - 1944 to 10-28 1944, and that I last saw her alive on 10-28 - 1944

Immediate cause of death	Duration
Cerebrovascular accident	1 week
Auricular Fibrillation	"
Due to Arteriosclerotic H.D & Hypertension	7
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. H. Kerr, Jr. M.D.
M. D.
Address Balto City Hosp. Date signed 11/2/44

G22048 ✓ G22048

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 83A

MARYLAND RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2203 Penrose Ave.
(c) Hospital or institution: No
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2203 Penrose Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORENCE SAPPINGTON TOUCHTON

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: no

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Byron
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/26/1876

8. AGE: Years 68 | Months 0 | Days 6 | If less than one day: hr. min.

9. Birthplace Harford Co., Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Harrison Fink
13. Birthplace England

MOTHER
14. Maiden Name Sarah Knight
15. Birthplace England

16 (a) Informant Mr. Rowlan Touchton
(b) Address 2203 Penrose Ave.

17 (a) Burial (b) Date thereof 10/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Rock Run Cem.
Location Harford Co. Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b)
(Date filed by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 26. 1944, at 6:00PM

21. I certify that death occurred on the date above stated; that I attended deceased from May - 1943 to Oct. 26 1944 and that I last saw h[illegible] alive on Oct 23 - 1944

Immediate cause of death

Hypostatic Pneumonia

Due to cerebral-Hemorrhage

Due to Arterio Sclerosis

Duration
1 Day
1942
10 yrs.

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Marie Ltd. Brooks M. D.
Address 2162 W. Fulton Ave. Date signed Oct 27 '44

Huntington Williams Registrar

VS 150

G22049

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22049

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Belvedere & Greenspring Ave
(c) Hospital or institution: Levindale

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Greenspring Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Yudis Freedman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Tony +

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Rugova N.W. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Victor R. -
13. Birthplace

MOTHER
14. Maiden Name Etta R. -
15. Birthplace

16 (a) Informant Samuel Freedman
(b) Address 1400 E. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-29-44 (month) (day) (year)
(c) Cemetery or crematory Pikesville Mt. Carmel
Location

18 (a) Funeral director Jos. Levine Inc
(b) Address 1739 E. Balto St

19 (a) Date received OCT 30 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1944, at 2:30 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13 1932, to 10-29 1944, and that I last saw h[er] alive on 10-29 1944.

Immediate cause of death: Coronary Thrombosis — Duration:
Due to: Hypertension, arteriosclerosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Edmund Levin M.D.
Address Levindale Date signed 10/30/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully prepared. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c

Registered No. G22050

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address: Belvedere & Green Spring Ave
(c) Hospital or institution: Levindale
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 1/2
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. Belvedere & Green Spring Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME DINA WEINER

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Sam Weiner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day: hr. min.

9. Birthplace (Town, county and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Bernard Brutzer
13. Birthplace Russia

MOTHER
14. Maiden Name Rosa —
15. Birthplace Russia

16 (a) Informant Dave Snyder
(b) Address 2904 Springfield Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-44 (month) (day) (year)

(c) Cemetery or cemetary Hebrew Mt Carmel
Location

18 (a) Funeral director Jacob Feire Inc
(b) Address 1434 E. Balto St

19 OCT 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29 1944, at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-4- 1943 to 10-28 1944, and that I last saw h[illegible] alive on 10-29 1944.

Immediate cause of death: Paralysis Agitans — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. Edmund Peirce

Address Levindale Date signed 10/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G22051

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 7-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 3 days

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
City or town Medellin (If outside city or town limits, write RURAL and give town)
(d) Street No. La Primavera (Rural give location)
(e) Citizen of foreign country Colombia (Yes or No)
If yes, name country South America

3 (a) FULL NAME Rev. Fr. Juan Maria Restrepo SARMILLO, S.J.

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-96

8. AGE: Years	Months	Days	If less than one day
48	2	22/23	hr. min.

9. Birthplace S.A. (Town, county, and state)
10. Usual Occupation Clergyman
11. Industry or business

FATHER
12. Name Nicanor Restrepo
13. Birthplace S.A.

MOTHER
14. Maiden Name Margarita Jaramillo
15. Birthplace S.A.

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 15/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ?
Location Medellin, Colombia, South America

18 (a) Funeral director H. W. Mears and Son
(b) Address 505 N. Calvert St.

19 OCT 30 1944 (c) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1944 at 9 55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1944 to Oct 28 1944, and that I last saw h[illegible]ive on Oct. 25 19 44

Immediate cause of death	Duration
Post operative shock	
Due to Intestinal Obstruction	
Due to peritonitis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-24-44
Major findings of operation: Peritonitis of large-duodenum (mid) mesocolon. 2nd unclosed lower duodenum
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. C. Huddleman M. D.
Address Jot N. Date signed 10-28-44

G22052

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83B

Registered No. G22052

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution:
Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 60yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4900 Litchfield Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME COHEN, JENNIE

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1865

8. AGE: Years: 79 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business: House Work

FATHER
12. Name: Louis Schmovitz
13. Birthplace: Russia

MOTHER
14. Maiden Name: Leah ?
15. Birthplace: Russia

16 (a) Informant: Simon Cohen
(b) Address: 3620 Lucille Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof October 30 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cem
Location: E Baltimore St

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

OCT 30 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27 1944, at 5:50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 22 1944 to Oct. 27 1944, and that I last saw her alive on Oct 27 1944

Immediate cause of death: Cardio-resp. failure — Duration

Due to Cerebro-vascular thrombosis

Due to Arteria-sclerosis-generalized

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sol Levinson M. D.
Address Sinai Hospital Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22053

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 302 Chestnut Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo W Johnson

3 (b) If veteran, name war: W
3 (c) Social Security Account No.:

4. Sex: M | 5. Color or race: W. | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lossie Rogers

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 28 1890

8. AGE: Years	Months	Days	If less than one day
53 55	10	0	hr. min.

9. Birthplace Waverly Va (Town, county, and state)
10. Usual Occupation General Sales Manager
11. Industry or business Kinsey Distillery Co

FATHER
12. Name Thomas L Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Mira Lee Harrison
15. Birthplace Va

16 (a) Informant Mason W Johnson
(b) Address Virginia Beach Va

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore Md

18 (a) Funeral director William Cobourn
(b) Address 1219 E Cont St

19 (a) OCT 30 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1944, at 11:30 A M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L Graham M.D. Medical Examiner.
Date signed Oct 28

G22054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22054 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully entered; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rehoboth & Pangman Ave
(c) Hospital or institution: West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2307 Linnard Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George Palmer Vickers

3 (b) If veteran, name war: —
3 (c) Social Security Account No.:

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Cora F.

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.) July 6 1874

8. AGE: Years 70 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Tile Tutor + Granite Co

FATHER
12. Name Horace Vickers
13. Birthplace Md

MOTHER
14. Maiden Name Mary J Lusby
15. Birthplace Va

16 (a) Informant Lowell Vickers
(b) Address 2307 Linnard Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/1/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge
Location Pikesville Md

18 (a) Funeral director Miller & Leppo
(b) Address 319 N Gay St

19 (a) (Date received) OCT 30 1944 (Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1944, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/28 1944 to 10/28 1944, and that I last saw h.s.w.m. alive on 10/28 1944.

Immediate cause of death Cerebral Vascular Accident — Duration:

Due to Hypertensive Heart Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert DeBallesteros

Address West Bal. Gen. Hosp. Date signed 10/28/44 M. D.

Approved: Robert DeBallesteros M.D. Oct. 29, 1944

G22055 Pattie ✓ G22055

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1718 E. Lavrale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen C. Poyzyle

3 (b) If veteran, name war: N
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John
6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): April 20 1901
8. AGE: Years: 43 Months: 6 Days: 8 If less than one day: hr. min.
9. Birthplace: Cockeysville Md (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: James Mansfield
13. Birthplace: England

MOTHER
14. Maiden Name: Mary Flynn
15. Birthplace: Cockeysville Md.

16 (a) Informant: Mrs. Esther C. Kolk
(b) Address: 1818 N. Register St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/31/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc
(b) Address: 127 St. Paul St

DEC 30 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1944, at 805 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1944 to 10/28 1944 and that I last saw he alive on 10/28 1944.

Immediate cause of death: Cerebral Failure — Duration

Due to: Coronary Thrombosis

Due to:

Other Conditions: Saddle Embolus Pulmonary Artery

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations: —

of autopsy: —

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Nelson Saunders M.D.

Address: 4 Forsyth Road Date signed: 10/30/44

G22056

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G22056 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1931 Herbert st.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1931 Herbert St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John W. Weber

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) ~~Single~~, married, ~~widowed or divorced~~: Married

6 (b) Name of ~~husband or~~ wife: Mary Weber

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 30th 1882

8. AGE: Years 62 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Paper Hanger

FATHER
12. Name (Unknown) Weber
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Mary Weber
(b) Address 1931 Herbert st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

19 OCT 30 1944 (b) Huntington Ave Baltimore, Md.
(Date rec'd by Local Reg.) (Signature)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27th 1944 at 2 30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1 1944 to Oct 27 1944, and that I last saw h. Co-alive on Oct 27 1944.

Immediate cause of death	Duration
Acute Pulmonary Edema (Recurrent)	9 mos
Due to Acute Heart Failure (Recurrent)	2 mos
Due to Hypertension & Chronic Myocarditis	unknown
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry Cushman M.D.

Address 1911 W North Ave Date signed 10/30/44

D. Houck 1929 W. North Ave Ba 2162

G22057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D ✓

Registered No. G22057

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2824 Clifton ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2824 Clifton ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edgar W. Roe

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of ~~husband or~~ wife Lida D. Roe
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 31st 1875

8. AGE: Years	Months	Days	If less than one day
69	6	25	hr. min.

9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Naval Officer
11. Industry or business Navy Yard - D.C.

FATHER
12. Name John W. Roe
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Amada E. Hooper
15. Birthplace Balto. Md.

16 (a) Informant Lida D. Roe
(b) Address 2824 Clifton Ave

17 (a) Burial (b) Date thereof 10/30/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 OCT 30 1944 Huntington Williams, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26th 1944 at 6 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/1/44 19 to 10/26/44 19 and that I last saw h~~im~~ alive on 10/25/44 19

Immediate cause of death Collapse
Coronary Thrombosis
Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

Duration: Months / Days / Hours / Minutes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] MD
Address 1929 W North Ave Date signed 10/28/44

VS 150

G22058

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

171a

Registered No. G22058

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 504 E. 36 St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Markell

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 81 | Months | Days | If less than one day: hr. min.

9. Birthplace: Shipbuildstown W Va (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: James F Markell
13. Birthplace: Shipbuildstown W Va

MOTHER
14. Maiden Name: Elizabeth Swearingen
15. Birthplace: Shipbuildstown W Va

16 (a) Informant: Eliza Sedalia
(b) Address: 825 Forth Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)
(c) Cemetery or crematory: Elmwood
Location: Shipbuildstown W Va

18 (a) Funeral director: Pilgrim Co Inc
(b) Address: 1217 E Pratt St

19 (Date received by registrar) OCT 30 1944

Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1944, at 7 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 23 1944 12:15 P.M.
(b) Where did injury occur? Greenmount & 35th St
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work?
(d) Means of injury struck by shutter

23. Signature: Robert E. Fraser M.D. Medical Examiner
Date signed Oct. 31 1944

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22059

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

Registered No. G22059

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 306 W. 28th Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 306 W. 28th Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1851

8. AGE: Years	Months	Days	If less than one day
93			hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Not Known
13. Birthplace Va.

MOTHER
14. Maiden Name Nancy Cole
15. Birthplace Va.

16 (a) Informant Mr. Alexander Robinson
(b) Address 306 W. 28th Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery Cem
Location A. A. Co., Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 OCT 30 1944 (b) Huntington Williams, M.D. Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28, 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15, 1944, to Oct 28, 1944, and that I last saw h alive on Oct 26, 1944

Immediate cause of death Hypostatic Congestion Broncho Pneumonia — Duration 2 yr

Due to

Due to

Other Conditions Bronchitis (Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Marie Alston, M. D.
Address 312 E 23rd St Date signed 10-31-44

G22050 ✓ G22050

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked. Every correct are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 930 W. Franklin St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 930 W. Franklin St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Annie Hopkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9, 1877

8. AGE: Years	Months	Days	If less than one day
67	1	17	hr. min.

9. Birthplace Frederick Co., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Louis Peach
13. Birthplace Md.

MOTHER
14. Maiden Name Emily Wright
15. Birthplace Md.

16 (a) Informant Mr. Harry Hopkins
(b) Address 930 W. Franklin St.

17 (a) Burial (b) Date thereof 10-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location New Market, Frederick Co, Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 558 W. Biddle St.

OCT 30 1944 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH Oct. 27 1944, at 7:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Mch 15 1942 to Oct 27 1944, and that I last saw h[illegible] alive on Oct 27 1944

Immediate cause of death Myocarditis — Duration 3 years
Due to
Due to
Other Conditions Dry gangrene
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L-H Watts M. D.
Address 515 Cathedral Date signed 10/31/44

G22051

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

G22051
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 531 Sheridan Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md County
(b) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 531 Sheridan Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edna Wells Bremer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Mark C. Bremer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 9-1860

8. AGE: Years 84 | Months 1 | Days 19 | If less than one day hr. min.

9. Birthplace West Virginia
(Town, county, and state)

10. Usual Occupation at Home

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Lee M. Bremer
(b) Address 531 Sheridan Ave

17 (a) Cremation (b) Date thereof Oct 30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director Robt C. & B.M. Walters
(b) Address Pratt & Stricker Sts

OCT 30 1944 (a) (b) Huntington Williamsport Md.
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1944, at 1 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1944 to Oct 28 1944, and that I last saw h— alive on Oct 28 1944

Immediate cause of death: Chron. Myocarditis — Duration 5 yr+

Due to

Due to

Other Conditions Arterio Sclerosis — 1 yr

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. W. Busby M. D.
Address 531 Sheridan Ave Date signed Oct 28

G22062

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G22062

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 Mountmor Ct.
(c) Hospital or institution:

15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Mountmor Ct.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Carter

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: F
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Phillip
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/6/1880

8. AGE: Years 64 | Months 9 | Days 20 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business Domestic

FATHER
12. Name Perry Chww
13. Birthplace Md

MOTHER
14. Maiden Name Frances
15. Birthplace Md

16 (a) Informant Veronica Francis(D)
(b) Address 1523 Mountmor Ct.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Balto. Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

OCT 30 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/44 19 at 9:05 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 19[illegible] to 10/26 19[illegible]; and that I last saw h[illegible] alive on 10/26 19[illegible].

	Duration
Immediate cause of death: Lobar Pneumonia	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M. D.
Address 739 [illegible] Date signed 10-30-44

G22053

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22053

MARGIN RESERVED FOR BINDING

PLEASE WRITE (PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct spelling is important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 917 Wash Blvd.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 Washington Blvd (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John E Bathgate

3 (b) If veteran, name war

3 (c) Social Security Account No. 217-16-4459

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 29-1884

8. AGE: Years 59 | Months 10 | Days 27 | If less than one day hr. min. 29

9. Birthplace Baltimore Md (city, county, and state)

10. Usual Occupation Watchmen

11. Industry or business Hecker Dept Store

FATHER
12. Name Chas Bathgate
13. Birthplace Howard Co Md

MOTHER
14. Maiden Name Elizabeth Mullinnix
15. Birthplace Anne Arundel Co Md

16 (a) Informant Mrs E E Bathgate
(b) Address 538 Wash Blvd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem
Location

18 (a) Funeral director Charles P Powell
(b) Address 2427 Edmondson Ave

19 OCT 30 1944 Huntington Williams, M.D.
(Date received by local registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28- 1944, at 9 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1st 1941 to Oct 28 1944 and that I last saw h~~im~~ alive on Oct 28th 1944.

Immediate cause of death

Cerebral Hemorrhage — Duration 1 day

Due to Hypertension — 3 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry H Kates M. D.
Address 517 Scott St Date signed 10/30/44

Harry H Kates

G22054

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registered No. G22054

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered. Physicians: please correct age is especially important. In case write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4307 Hampenthave
(c) Hospital or institution: Bates Convalescent Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4703 Hampenthave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William J. Coolahan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M.

5. Color or race W.

6 (a) Single, married, (widowed) or divorced.

6 (b) Name of husband or wife Catherine C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1861

8. AGE: Years 83 | Months | Days | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name ?

FATHER 13. Birthplace ?

MOTHER 14. Maiden Name ?

MOTHER 15. Birthplace ?

16 (a) Informant Wanda C. Gatto

(b) Address 4307 Hampenthave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-30-44 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location

18 (a) Funeral director L. J. Koch

(b) Address 5206 Harford Rd

19 (Date received) OCT 30 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 1944 at 5:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 29 1944 to Oct 26 1944 and that I last saw him alive on Oct 26 1944.

Immediate cause of death cerebral hemorrhage

Duration 24 days

Due to Hypertensive Cardio-Vascular Renal disease

Due to Chronic myocarditis

Other Conditions arteriosclerosis atrophic cirrhosis ? Carcinoma stomach

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. V. Harlold M. D.

Address 4706 Harford Road Date signed 10/30/44

G22065

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163H

G22065 Registered No.

Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland MANSE Court
(b) Street address K46 Mans Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. K46 Mans Court 2nd flt. Manse et mans
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Newman alias Waters

3 (b) If veteran, name war	3 (c) Social Security Account No.
World II	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Negro	Married

6 (b) Name of husband or wife Janet
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 17-1908

8. AGE: Years	Months	Days	If less than one day
36	8	9	hr. min.

9. Birthplace Pocomoke Md
(Town, county, and state)

10. Usual Occupation
11. Industry or business

MOTHER
12. Name Mary Allen
13. Birthplace Md

FATHER
14. Name Edward Waters
15. Birthplace Md

16 (a) Informant Janet Waters
(b) Address 1446 Manse Ct

17 (a) Burial (b) Date thereof 10-31-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location Balto City

18 (a) Funeral director Samuel W. Bragg & Son
(b) Address 638 N. Richmond St.

OCT 30 1944 (b)
(Signature of registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1944, at 10 P.M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Asphyxiation

Due to Illuminating gas.

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-26- at Apartment P. M.
(b) Where did injury occur? 446 Manse Court
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Kitchen gas range

23. Signature Howard J. Devilbiss M.D.
Medical Examiner.
Date signed 10-27-44

G22066

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 33a

G22066 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1814 N. Spring St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1814 N. Spring St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Edward Scott.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Col	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/13/1896

8. AGE: Years	Months	Days	If less than one day
48	4	14	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER 12. Name Joseph. E. Scott. Md
13. Birthplace

MOTHER 14. Maiden Name Margaret Parles
15. Birthplace Md

16 (a) Informant Margaret Scott
(b) Address 1814 N. Spring St

17 (a) Burial (b) Date thereof 10-30-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto Co

18 (a) Funeral director Payne Sanders
(b) Address 1442 E. Preston St

OCT 30 1944
(Date rec'd by registrar) Huntington Williams, Mgr

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 20 1944 to Oct 27 1944, and that I last saw h[im] alive on Oct 27 1944.

Immediate cause of death Acute myocarditis — Duration 1 Day
Due to Coban Pneumonia — 3 Days
Due to Lobar Pneumonia — 35 Days
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Wm. L. Lemmy M. D.
Address 920 E. Chase Date signed 10-30-44

G22057

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

§2a

G22057
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1817 Ruxton Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

a. State Md b. County

c. City or town Balto
(If outside city or town limits, write RURAL and give town)

d. Street No. 1817 Ruxton Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

15

3 (a) FULL NAME Inez Esther Riegel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Louis Riegel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 44 | Months | Days | If less than one day hr min.

9. Birthplace Balto, Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name —

13. Birthplace Md

MOTHER 14. Maiden Name —

15. Birthplace Md.

16 (a) Informant Louis Siegel

(b) Address 1817 Ruxton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-44 (month) (day) (year)

(c) Cemetery or crematory Greenmount Cem. Co.

Location Rosedale

18 (a) Funeral director Jack Lewis Inc.

(b) Address 1434 E. Balto. St

OCT 30 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29-44 19 at 11 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/29 1944 to 10/29 1944, and that I last saw h alive on 10/29 1944

Immediate cause of death Cerebral Hemorrhage

Duration less than 1 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Philip F. Lerner M. D.

Address 2401 N. North Ave Date signed 10/29/44

For Dr H.L. Hollander, by Howard F. Madden, M.D.

G22068

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G22068

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) -

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 924 S. Charles St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Leona M. Gough Leona M. Gough

3 (b) If veteran, name war -

3 (c) Social Security Account No. -

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Divorced

6 (b) Name of husband or wife Douglas Gough
6 (c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) 12-22-93

8. AGE: Years	Months	Days	If less than one day hr.	min.
50	10	6		

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation -

11. Industry or business -

FATHER
12. Name Michael G. Webb
13. Birthplace New Jersey

MOTHER
14. Maiden Name Annie Malinger
15. Birthplace Pennsylvania

16 (a) Informant Father
(b) Address 924 S. Charles St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore

18 (a) Funeral director John F. Denny, Inc.
(b) Address 715 Light Street

19 (a) OCT 30 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1944 to 10-28 1944 and that I last saw her alive on 10-28 1944.

Immediate cause of death	Duration
Metastasis of Lungs	
Due to Ovarian Neoplasm	
Due to	
Other Conditions Parkinsonism	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Ehrlich M. D.
Address 1213 Light St Date signed 10-28-44

Uher

G22069

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G22069
Registered No.

MARG... RESERVED FOR B...DING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Balto. General Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1119 Riverside Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Casper Uher

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October ? 1867

8. AGE: Years	Months	Days	If less than one day
77			hr. min.

9. Birthplace Europe
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Casper Uher
13. Birthplace Europe

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant James Uher
(b) Address 1119 Riverside Ave.

17 (a) Burial (b) Date thereof Oct. 31, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore

18 (a) Funeral director John F. Penny, Inc.
(b) Address 715 Light St.

19 OCT 30 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1944, at 2:35 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-15- 1944 to 10-29- 1944, and that I last saw h(im) alive on 10-29- 1944.

Immediate cause of death	Duration
Hypostatic pneumonia	
Due to Hypertensive arterio-sclerotic heart disease	
Due to Cerebral Vascular Accident	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Uhler M. D.

Address 1213 Light St Date signed 10-29-44

Neibuhr

G22070

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 42D

G22070 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 833 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 mos.
(e) Length of stay in Baltimore (yrs., mos., or days) 32 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 833 W. Fayette St. (If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME William H. Neibuhr

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Elizabeth H. Neibuhr
6 (c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Apr. 21. 1868

8. AGE: Years	Months	Days	If less than one day
76	6	7	hr. min.

9. Birthplace Germany (Town, county and state)
10. Usual Occupation Retail Shoe Merchant.
11. Industry or business

FATHER
12. Name George N. Neibuhr
13. Birthplace Germany

MOTHER
14. Maiden Name Unknown
15. Birthplace Germany.

16 (a) Informant Elizabeth H Neibuhr
(b) Address 833 W. Fayette St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31. 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Md.

18 (a) Funeral director Mt. Nus - John W. Geupel - Son
(b) Address 901 W. Fayette St.

19 (a) (b) Registrar Huntington Williams, M.D.

OCT 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1944, at 11 40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 10 1943 to Oct 28 1944
and that I last saw h alive on Oct 28 1944

Immediate cause of death Endocarditis

Duration
10 mo
To My Knowledge

Due to ?

Due to ?

Other Conditions arterio Sclerosis?

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. D. Pinkett M. D.
Address Mercy Hospital Date signed Oct 29-44

G22071

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

97

G22071 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1219 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Rosa Lecatur

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Negro | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: George

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 1867

8. AGE: Years 97 | Months -3 | Days - | If less than one day: hr. min. 1847

9. Birthplace Santee, Va (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Edward Smith
13. Birthplace Va

MOTHER
14. Maiden Name Harriett ??
15. Birthplace Va

16 (a) Informant Catherine Le Blanc
(b) Address Philadelphia, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 30, 1944 (month) (day) (year)
(c) Cemetery or crematory Laurel Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. George A. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Huntington Williams, M.D. (Local registrar) Registrar

OCT 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 25 1944, at 1 04 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec. 8 1940, to Oct 25 1944, and that I last saw her alive on Oct 25 1944.

Immediate cause of death: Generalized arterio-sclerosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature G H Banfield, M D
Address Provident Hospital Date signed 10/26/44

G22072

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. G22072

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Linden Hospt
(c) Hospital or institution
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town (If outside city or town limits, write RURAL and give town) 6 Pimlatte Town. Hospe
(d) Street No. 1201 W Eldonont St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Leha Goldiner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Kalman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1875

8. AGE: Years 69 | Months | Days | If less than one day hr. min.

9. Birthplace Russia. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Not Known
13. Birthplace Russia.

MOTHER 14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hospt Records
(b) Address

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-30-44 (month) (day) (year)
(c) Cemetery or crematory Mary Montefiore
Location Wash. Blvd.

18 (a) Funeral director Jack Levis Son
(b) Address 1439 E. Balto St.

OCT 30 1944 (Date rec'd by registrar)

(a) (b) Huntington Williams, Md

Approved by Howard J. Madden, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11:35 AM, 10/29, 1944, at 11:35 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 9/29, 1944, to 10/30, 1944, and that I last saw her alive on 10/29, 1944.

Immediate cause of death Osteomyelitis — Duration

Due to Fracture Neck Femur, Left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence August 3, 1944 at 6 P. M
(c) Where did injury occur? Pimlatte Conv. Home. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home. (Specify type of place) While at work? No.
(e) Means of injury Slipped on the floor at home.

23. Signature Elmer L. Hoffman, M. D.

Address Sinai Hospt. Date signed 9/30/44

G22073

Jo #78811

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12B

G22073 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Eastern Avenue

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yr.9mos.29da.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1030 Wilmot Ct. (If rural give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country

3 (a) FULL NAME James Kasda Jr. James C. Kasda Jr.

3 (b) If veteran, name war: None

3 (c) Social Security Account No.:

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) July 15, 1917

8. AGE: Years	Months	Days	If less than one day
27	3	12	hr ——— min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Sheet metal worker

11. Industry or business

FATHER

12. Name James Kasda

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Anna [illegible] Lissy

15. Birthplace S. Wilmington Ill.

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer

Location Frederick Road, Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.

(b) Address 1735 Harford Avenue

19 (a) OCT 30 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1944, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from dec. 28, 1942, to Oct. 27, 1944, and that I last saw him alive on Oct. 27, 1944.

Immediate cause of death: Heart failure — Duration 1 hr

Due to: Pulmonary tuberculosis — Duration 2½ yrs

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence ——— at ——— M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harold Dillon M. D.

Address Balto City Hosp. Date signed 10/27/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

G22074

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

10

Registered No. G22074

1. PLACE OF DEATH:
(a) Baltimore City, Maryland ✓
(b) Street address 245 S Regester St
(c) Hospital or institution: Sydenham ✓
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md ✓ (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give Town)
(d) Street No. 245 S. Regester St
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME CAROLYN Carolyn Salkowski - Carolyn Salkowski ✓

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 1-1937

8. AGE:	Years	Months	Days	If less than one day
	7	2	27	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Joseph Salkowski
13. Birthplace Indiana

MOTHER
14. Maiden Name Josephine Dracy
15. Birthplace Baltimore Md.

16 (a) Informant Joseph Salkowski
(b) Address 245 S. Regester St

17 (a) Burial (b) Date thereof Oct 31-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Rosary's
Location Gerard Mill Road

18 (a) Funeral director John A. Grebiancheck Jr
(b) Address 423 S Paca St

OCT 30 1944
(Date rec'd by registrar)

Huntington Williams, M.D.
Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-28 1944, at about 1 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-2 1944, to 10-28 1944, and that I last saw h alive on 19

Immediate cause of death Diphtheria

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Tracheotomy

Major findings of operation:

Anatomical Diag. 10/29/44

of autopsy: Not a post

Duration
6 day.

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Clive R Birmingham M. D.

Address J. H. H. Date signed 10/29

G22075

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

181

Registered No. G22075

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West. Baltimore General Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 717 N. Monroe ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Carole D Karns

3 (b) If veteran, name war None
3 (c) Social Security Account No. None

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: Infant.
6 (b) Name of husband or wife: Infant.
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 3 9 1942
8. AGE: Years 2 | Months 7 | Days 19 | If less than one day 9½ hr. min.
9. Birthplace Balto Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name John O Karns.
13. Birthplace Penna

MOTHER
14. Maiden Name Helen B Wagner
15. Birthplace Balto Md.

16 (a) Informant John O Karns.
(b) Address 717 N. Monroe St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-44 (month) (day) (year)
(c) Cemetery or crematory Woodbrook Memorial
Location Washington Blvd

18 (a) Funeral director Charles W. Kuebelbeck
(b) Address 703 McHenry St.
(c) (Date received by registrar) OCT 30 1944 (Huntington Williams M.D.)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1944 at 9:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Toxemia due to 1st, 2nd & 3rd degree burns

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct 27 1944 4 P.M.
(b) Where did injury occur? 717 N. Monroe St.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
Means of injury Clothes caught fire playing near stove

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Oct. 28 1944

G22076

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22076 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5313 Edmondson Ave
(c) Hospital or institution: Good Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 weeks
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1253 Sargeant St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary A. Forney.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race colored | 6 (a) Single, married, widowed, or divorced married.

6 (b) Name of husband or wife Arthur F. Forney.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8th 1894

8. AGE: Years 50. | Months 3. | Days 20. | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation House work

11. Industry or business at Home

FATHER
12. Name Leo Schwalenberg
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mary Curran
15. Birthplace Baltimore Md

16 (a) Informant Mr Arthur F. Forney
(b) Address 1253 Sargeant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location 4300 Old Frederick Road

18 (a) Funeral director John F. Curran & Son
(b) Address 901-03 Hollins Street

19 OCT 30 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28th 1944; at 1:30 P M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 4 1944 Oct 28 1944
and that I last saw h alive on Oct 28 1944

Immediate cause of death

	Duration
Coronary Thrombosis	3 Days
Due to Cerebral Hemorrhage	1 day
Due to Hypertension	3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify which place)
(e) Means of injury

23. Signature Geo E Urban
Address 603 21st Ave Date signed 10-30-44
Catonsville, Md.

MARG RESERVED FO
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22077

JO #90046

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

Registered No. G22077

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 16

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1046 Brantley St. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Carl E. Brown

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1944

8. AGE: Years --- | Months -2- | Days -10- | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Brown
13. Birthplace Florida

MOTHER
14. Maiden Name Evelyn McWillin
15. Birthplace North Carolina

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brookfield Ave
Acting for Williams, Mgr.

19 OCT 30 1944 (Date Rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1944, at 9:05PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 2, 1944 to Oct. 28, 1944, and that I last saw him alive on Oct. 28, 1944.

	Duration
Immediate cause of death: Respiratory failure	
Due to: Aspiration of vomitus	
Due to: infectious hepatitis	3 weeks
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: hepatitis

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Ellis Fier
Address Baltimore City Hosp. Date signed 10-29-44

VS 150

G220732034

BALTIMORE CITY HEALTH DEPARTMENT X V G22078

CERTIFICATE OF DEATH 46D

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town WASHINGTON (If outside city or town limits, write RURAL and give town)
(d) Street No. 85 R. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Dora Little

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: black

6 (a) Single, married, widowed, or divorced: Sep.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-6-83

8. AGE: Years 61 | Months 4 | Days 22 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Henry Alexander
13. Birthplace N.C.

MOTHER 14. Maiden Name Helen Pickenpacke
15. Birthplace N.C.

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (b) Date thereof 10/30/44 (burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington, D.C.
Location

18 (a) Funeral director Milton C. Malone
(b) Address 424-K-5th. Wash., D.C.

OCT 30 1944 Huntington Williams, M.D. Registrar

VS 330

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1944 at 6 5-5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1944 to 10/28 1944, and that I last saw her alive on 10/25 1944.

Immediate cause of death: cardio-respiratory failure — Duration

Due to Uremia

Due to carcinomatosis?

Other Conditions Hypertensive cardiovascular disease; Intestinal Obstruction

(Include pregnancy within 3 months of death)

Date of operation 10/17 10/19

Major findings of operation Annular Carcinoma of Rectosigmoid

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. C. Hagedorn M. D.
Address 301 St. Date signed 10-29-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22079

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G22079

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1113 W. Franklin
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1113 W. Franklin (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy Shipley Houston

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Daniel Houston

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 1912

8. AGE: Years	Months	Days	If less than one day
32	8	6	hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Private Wife

11. Industry or business

FATHER
12. Name Henderson Johnson
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Daisy Jackson
15. Birthplace Baltimore Md

16 (a) Informant Mrs Edna Ringold
(b) Address 1113 W Franklin St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/31/1944 (month) (day) (year)
(c) Cemetery or crematory Western Star Cemetery
Location

18 (a) Funeral director Mrs Katie R. Williams (b) Address 3 Schroeder St.

OCT 30 1944

19 (a) (Date rec'd by registrar) (b) Huntingtown Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/26/1944, at 8.05 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Hypertensive Cardio-vascular renal disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Dwight B. McNally M.D. Medical Examiner.

Date signed 10/27/44

VS 151

G22080

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G22080

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) 16

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1705 Riggs Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Garland Baby Boy Robinson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	SINGLE

6 (b) Name of husband or wife NONE
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1944.

8. AGE: Years	Months	Days	If less than one day
		16	17 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business None

FATHER
12. Name Landon Robinson
13. Birthplace Greenwood, S.C.

MOTHER
14. Maiden Name Annie Thomas.
15. Birthplace S.C.

16 (a) Informant Mr Louden Robinson.
(b) Address 1708 Riggs Ave

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10/30/1944 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location West Port Md

18 (a) Funeral director Mrs Kate R. Williams.
(b) Address 2224 Schroeder St.

OCT 30 1944
(Date rec'd by registrar)

(b) Huntington Williamsport, Md.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-10 1944, to 10-27 1944, and that I last saw him alive on 10-26 1944.

Immediate cause of death Respiratory failure

Due to Prematurity

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas J Evans M. D.
Address Univ. Hospital Date signed 10-27-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22081

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22081

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Balto. Gen. Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-9
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 841 China Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred Petross

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 67 | Months - | Days | If less than one day hr. min.

9. Birthplace Cardena Co. Va.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business

FATHER
12. Name Jack Peatross
13. Birthplace Cardena Co. Va.

MOTHER
14. Maiden Name Lucy Courtney
15. Birthplace Cardener Co. Va

16 (a) Informant Thomas Peatross
(b) Address 1014 No 5th. St. Richd. Va.

17 (a) (Burial, cremation, or removal) (b) Date thereof Oct 31, 44 (month) (day) (year)

(c) Cemetery or crematory Richmond
Location

18 (a) Funeral director Walter B. Griggs
(b) Address 109 W. Hamilton St.

19 (Date received by registrar) OCT 30 1944 Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1944 at 7:20 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerotic Cardio-vascular Disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Moorhead M.D.
Medical Examiner.
Date signed 10-27-44

G22082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G22082 Registered No.

MARRIED FOR BINDING — RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1218 N. Baltimore St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1218 N. Baltimore St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine a. Rohrbach

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jacob Rohrbach
(c) If alive, give age 79 years

7. Birth date of deceased (mo., day, yr.) April 18, 1873

8. AGE: Years	Months	Days	If less than one day
71	6	10	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Joseph Heisinger
13. Birthplace Germany

MOTHER
14. Maiden Name —
15. Birthplace Germany

16 (a) Informant Mrs. Jacob J. Rohrbach
(b) Address 1218 N. Baltimore St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md.

18 (a) Funeral director F. B. Hippert & Son
(b) Address 1300 Eutaw Place

19 OCT 30 1944 Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 19 44 at 8.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 19 19 44 to Oct 28 19 44, and that I last saw h[illegible] alive on Oct 28 19 44.

Immediate cause of death Cancer of Lung

Duration 5 months

Due to Carcinosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature John F. Abbott M. D.
Address 450 E. Liberty St. Date signed 10-31-44

VS 150

G22083

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22083 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.a.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 713 N. Durham Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Thomas

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	married

6 (b) Name of husband or wife ROBERT
6 (c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) June 6 1904

8. AGE: Years	Months	Days	If less than one day
40	4	21	hr. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual Occupation House work (maid)
11. Industry or business Nurse's Home, Hamilton Road
FATHER 12. Name William Thompson J. H. H
FATHER 13. Birthplace South Carolina
MOTHER 14. Maiden Name Charlotte
MOTHER 15. Birthplace South Carolina
16 (a) Informant Roberta Thomas
(b) Address 713 N. Durham Street
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-44 (month) (day) (year)
(c) Cemetery or crematory Hollywell Cemetery
Location STROTHERS S. CAROLINA
18 (a) Funeral director William A Jackson
(b) Address 916 Pennsylvania ave
19 OCT 30 1944 (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION A.

20. DATE OF DEATH October 27, 1944, at 10.30 M

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon (Autopsy, Inspection or Inquiry) and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hypertensive Card.-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Morris M.D. Medical Examiner.
Date signed 10-27-44

G22034

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 132

Registered No. G22034

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 100 N. Bruce St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin Anthony

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-14-40

8. AGE: Years	Months	Days	If less than one day
4	5	14	hr. min.

9. Birthplace Md (town, county, and state)
10. Usual Occupation School
11. Industry or business

FATHER 12. Name Charley Anthony
13. Birthplace S.C.

MOTHER 14. Maiden Name Mary Cantine
15. Birthplace N.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Annex Funeral Co.

18 (a) Funeral director Joseph A. Shelly
(b) Address 1630 Bank St.

19 (a) [illegible] (b) Huntington Williams, M.D.
OCT 30 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1944 at 9 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1944 to Oct 28 1944 and that I last saw him alive on Oct 28 1944

Immediate cause of death Tuberculous meningitis — Duration ± 2 wks.
Due to Miliary Tuberculosis — ± 3 wks.
Due to — over
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy: Miliary tuberculosis Tuberculous meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ruth W. Anderson M. D.
Address John Hopkins Hospital Date signed 10/28/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22085

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

57 d

Registered No. G22085

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Wash (b) County.....
(c) City or town Coulee Dam
(If outside city or town limits, write RURAL and give town)
(d) Street No.....
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Georgianne Walker

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-5-20

8. AGE: Years	Months	Days	If less than one day
24	1	25	..... hr. ..... min.

9. Birthplace Ohio (Town, county, and state)

10. Usual Occupation Secretary

11. Industry or business

FATHER
12. Name Clayton Walker
13. Birthplace Ohio

MOTHER
14. Maiden Name Estelle Campbell
15. Birthplace Ohio

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Steubenville Ohio
Location

18 (a) Funeral director J. O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a)..... (b) Huntington Williams, M.D. Registrar

OCT 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1944 at 9:34 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1944 to Oct 30 1944 and that I last saw her alive on Oct 30 1944

Immediate cause of death: Pat - Aspiration pneumonia - bilateral coronary thrombosis - acute dilatation

	Duration
Due to.....	
Due to.....	
Other Conditions..... (Include pregnancy within 3 months of death)	

Date of operation.....

Major findings of operation: Ruptured coronary thrombosis

of autopsy: acute dilatation

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?.....
(Specify type of place)
(e) Means of injury.....

23. Signature Paul Reynolds M. D.
Address Johns Hopkins Hospital Signed 11/30/44

G22036

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No. G22036

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wilkins Ave
(c) Hospital or institution St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley & Eager Sts. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Sallie King

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife George F. King

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1863

8. AGE: Years 81 | Months | Days | If less than one day hr. min.

9. Birthplace ? (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John T. Delaney

13. Birthplace Ireland

MOTHER 14. Maiden Name Catherine King

15. Birthplace Ireland

16 (a) Informant Rita Wiedefeld

(b) Address 914 Greenmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral

Location Baltimore

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Greenmount Ave

OCT 30 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/28 1944 at 12.50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1944 to 10/28 1944, and that I last saw h.er alive on 10/28 1944.

Immediate cause of death Cardiac failure — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence 10-24-44 at ? M

(c) Where did injury occur? above residence (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no

(e) Means of injury Fell & fract.

23. Signature Jos. C. Pilewski M. D.

Address St. Agnes Hosp Date signed Oct 29 1944

For S.P.J. Pilewski, by Howard J. Mulling M.D.

G22037 Puryear

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G22037

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1200 Valley St - Baltimore
(c) Hospital or institution:
Home for the Aged
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10 months
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1200 Valley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Roberta Puryear

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: John Puryear

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual Occupation: None

11. Industry or business

FATHER
12. Name: Charles Everett
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Jenny Williams
15. Birthplace: Virginia

16 (a) Informant: Little Sisters of the Poor
(b) Address: 1200 Valley St. Baltimore

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31. 1944 (month) (day) (year)
(c) Cemetery or crematory: Cathedral
Location: Baltimore.

18 (a) Funeral director: Rita Wiedefeld
(b) Address: 914 Greenmount Ave

19 OCT 30 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-29- 1944, at 4 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1- 1944 to Oct 29-1944, and that I last saw her alive on Oct 28- 1944

Immediate cause of death: Edema Lungs — Duration: 1 day

Due to: Carcinoma Liver — Duration: 4 yrs

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature E Gill Hall

Address 1631 E. North Ave Date signed Oct 30 44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22038

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22038

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3676 Beech Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Wesley Ingle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife: Nellie R. Ingle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5, ? 1884

8. AGE: Years 60 ? | Months 1 | Days 23 | If less than one day hr. min.

9. Birthplace Georgia. (town, county, and state)

10. Usual Occupation Textile Worker.

11. Industry or business

FATHER
12. Name Thomas Ingle.
13. Birthplace S. C.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Nellie R. Ingle.
(b) Address Mt. Holly, N. C.

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Oct 30/44 (month) (day) (year)
(c) Cemetery or crematory Gastonia
Location North Carolina

18 (a) Funeral director Edmonds & Bourne
(b) Address 3615-17 Edmondson Ave.

19 (a) OCT 30 1944 (Registered by registrar) Huntington Williams, Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28, 1944, at 7:35 A. M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH Coronary arteriosclerosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. L. Wollenweber M.D. Medical Examiner.
Date signed October 30 1944.

G22039

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46 F

G22039 Registered No.

MARYLAND RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2928 Silver Hill Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2928 Silver Hill ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MATHIAS FELLENZ

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married.

6 (b) Name of husband or wife Marie Fellenz.

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) April 27, 1865

8. AGE: Years 79 | Months 6 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)

10. Usual Occupation

11. Industry or business Coal & Ice

FATHER
12. Name Mathias Fellenz.
13. Birthplace Germany.

MOTHER
14. Maiden Name Elizabeth Foster
15. Birthplace Germany

16 (a) Informant Mrs. Marie Fellenz.
(b) Address 2928 Silver Hill Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Calvery.
Location St. Louis, Mo.

18 (a) Funeral director G. Vernon Lemmon.
(b) Address 4614 Park Heights

19 (a) [illegible] (b) [illegible] registrar Huntington Williams

OCT 30 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1944 at 7 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Aug 9 1944, to Oct 30 1944, and that I last saw h[illegible] alive on 10/30 1944.

Immediate cause of death: Acute cardiac dilatation

Due to: Carcinoma of liver

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature]

Address 4710 Liberty Hts. Date signed 10/30. M. D.

G22090

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22090 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4 N. Port St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 N. Port St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Utz

3 (b) If veteran, name war: No

3 (c) Social Security Account No.: None

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Mary A.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 26 1864

8. AGE: Years 80 | Months 2 | Days 2 | If less than one day hr. min.

9. Birthplace Balto. (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER
12. Name Joseph Utz
13. Birthplace Germany

MOTHER
14. Maiden Name Stain
15. Birthplace Germany

16 (a) Informant Josephine Rickards
(b) Address 4 N. Port St

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10 31 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore Md.

18 (a) Funeral director Martin M.C. Duffy & Son
(b) Address Lombard & Others Sts.

19 (a) Huntingtown Williams, Md.
(Date rec'd by registrar) Registrar

OCT 30 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 1944 at 2:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1944 to Oct 28 1944 and that I last saw h[illegible] alive on Oct 28 1944

Immediate cause of death: Pulmonary Edema — Duration: 2 hrs.

Due to: Cardiac Vascular Disease

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H J Tankins M. D.

Address 100 N Milton Ave Date signed Oct 29 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR LANDING

G22091

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Female Nonwh 161a

G22091

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1402 N. Caroline ST
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3617 N. Margaret ST. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James Thomas Honsa

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days: 5 | If less than one day: hr. min.

9. Birthplace Balto Md (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name James Honsa
13. Birthplace St Clairville Ohio

MOTHER
14. Maiden Name Anna M Benesh
15. Birthplace Befain Ohio

16 (a) Informant Mr James Honsa
(b) Address 3617 St Margaret St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-44 (month) (day) (year)
(c) Cemetery or crematory Elm Hill Cem
Location Ritchie Highway

18 (a) Funeral director Hutton & Shilling
(b) Address 39/4 Hanover St

19 (a) (To be signed by registrar) (b) OCT 30 1944 Registrar

Washington Nathanson, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1944 at 9 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28- 1944, to 10-30 1944, and that I last saw h.m. alive on 10-30 1944.

Immediate cause of death Pneumonia — Duration

Due to Atelectasis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. E. Robertson M. D.
Address St. Josephs Hospital Date signed 10-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G22092

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

✓ G22092 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison + Linden Sts.
(c) Hospital or institution: Maryland General
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2800 Linden Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Annie E. Aro

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife George E. Aro
6 (c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 13 - 1876

8. AGE: Years	Months	Days	If less than one day
68	1	16	hr. min.

9. Birthplace Kent Co Md
(Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name /
13. Birthplace /

MOTHER
14. Maiden Name /
15. Birthplace /

16 (a) Informant George E Aro
(b) Address 2800 Linden Ave

17 (a) Burial (b) Date thereof 11 - 1 - 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto

18 (a) Funeral director Leonard J Krug
(b) Address 4305 Harford Rd.

(a) (b)
(Signature of local registrar) Registrar

10 30 1944
VS 15M

Huntington Williams Md

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1944, at 6:00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/8 1944, to 10/29 1944, and that I last saw her alive on 10/29 1944

Immediate cause of death Pulmonary Edema — Duration 2 days

Due to Hypertensive Cardiovascular Disease — 10 years

Due to

Other Conditions Uremia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Martin E. Strobel
Address Md. General Hosp. Date signed 10/29/44 M. D.

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G22093 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 N Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 67

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 N Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James D. O'Connell

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ethel O'Connell
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Oct 16 1877

8. AGE: Years	Months	Days	If less than one day
67	—	11	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Hotel Business
11. Industry or business

FATHER
12. Name Timothy O'Connell
13. Birthplace Ireland

MOTHER
14. Maiden Name Dora Ryan
15. Birthplace Ireland

16 (a) Informant Ethel O'Connell
(b) Address 400 N Broadway

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Loyola

18 (a) Funeral director Ulrich Funeral Home
(b) Address 2004 E. Orleans St

OCT 30 1944 (Date received by Registrar) (b) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27th 1944 at 1 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 14 1944, to Oct 27th 1944, and that I last saw h.. alive on Oct 27 1944.

Immediate cause of death Chronic nephritis (uremia)
Hemiplegia (rt) -
Due to Arterial hypertension + arterio-sclerosis -
Due to —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

Duration
Oct 27/44
Oct 14/44
2 yr
2 yr

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work? (Specify type of place)
(e) Means of injury —
23. Signature Jonas F. Krumrein M. D.
Address 722 N. Kenwood Ave Date signed 10/28/44

G22094

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

G22094 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1 S. EAST AVE.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 6
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 S. EAST AVE.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE NAGENGAST

3 (b) If veteran, name war NO

3 (c) Social Security Account No. NONE

4. Sex MALE

5. Color or race WHITE

6 (a) Single, married, widowed, or divorced. WIDOWER

6 (b) Name of husband or wife KATHERINE NAGENGAST

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) DEC. 18 1862

8. AGE: Years 81 | Months 10 | Days 10 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation HARDWARE MERCHANT

11. Industry or business FOR SELF

FATHER
12. Name HENRY NAGENGAST
13. Birthplace GERMANY

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace GERMANY

16 (a) Informant GERTRUDE GROVE (DAUGHTER)
(b) Address 3415 MAYFIELD AVE.

17 (a) BURIAL (b) Date thereof OCT. 31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory HOLY REDEEMER
Location BELAIR ROAD

18 (a) Funeral director Lilly & Jenkins Son
(b) Address 403 S. WOLFE ST.

19 (a) OCT 30 1944 Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH OCT. 28 1944, at 6PM M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Oct 28 1944 and that I last saw h[illegible] alive on Oct 28 1944

Immediate cause of death Chronic Nephritis — Duration 2 mos

Due to Arterio Sclerosis — 2 yrs

Due to Uraemic Coma — 2 mos

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. S. Gray M.D.

Address 6 W. Mt. Vernon Pl. Date signed Oct 30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

AB-87447 G22095

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

✓ G22095 13B Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6mos-12days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 28 Vincent St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Henry Spencer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: M | 5. Color or race: C | 6 (a) Single, married, widowed, or divorced: Married-Separated

6 (b) Name of husband or wife Lela
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 23-1900

8. AGE: Years 44 | Months 6 | Days 3 | If less than one day hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Henry Spencer
13. Birthplace N.C.

MOTHER: 14. Maiden Name Sophia Ellis
15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals(Records)
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Charles G. Cooper
(b) Address 512 N. Carrollton Ave.

19 (a) (Date received by registrar) Huntington Williams, M.D.

OCT 30 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1944, at 5.50PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4-14- 1944, to 10-26- 1944, and that I last saw h.2 alive on 2+ 26 1944.

Immediate cause of death: Heart failure — Duration
Due to: Pulmonary Tuberculosis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: — above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luis Dalmau
Address Resident Physician Baltimore City Hospitals Date signed 10/28/44 M. D.

LUIS DALMAU, M.D.

G22096

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G22096 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 1day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Harford Co.
(c) City or town Pylesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Mabel Akins

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 9, 1935

8. AGE: Years 9 | Months 10 | Days 21 | If less than one day hr. min.

9. Birthplace Harford Co., Md. (Town, county, and state)

10. Usual Occupation Child.

11. Industry or business

FATHER
12. Name Charles Aiken
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Mabel Lewis
15. Birthplace Harford Co., Md.

16 (a) Informant Mabel Aiken
(b) Address Pylesville Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Whitelock Home
Location Rocks Md

18 (a) Funeral director W. Harry Webb
(b) Address Jarrettsville Md

OCT 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1944, at 11 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1944, to 10-30 1944, and that I last saw her alive on 10-30 1944

Immediate cause of death 2nd & 3rd degree burns of trunk, thighs, & arms.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence 10-29 at 4 M
(c) Where did injury occur? Pylesville (City or town) Harford (County) Md (State)
(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at work?
(e) Means of injury burned by spilled Kerosene

23. Signature W. S. Lyon M. D.
Address University Hosp. Date signed 10-30

Affidavit by Thomas J. Mulvaia, M.D.

G22097

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G22097 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. Use no abbreviations. Do not write above the line. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 914 Baltic Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 914 Baltic Street (If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME George Edward Akehurst, Sr.

3 (b) If veteran, name war None

3 (c) Social Security Account No. 705-09-4995

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary E. Akehurst

6 (c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Dec. 12, 1873

8. AGE: Years 70 | Months 10 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Railroad Brakeman

11. Industry or business Retired

FATHER 12. Name George Thomas Akehurst

13. Birthplace Maryland

MOTHER 14. Maiden Name Elizabeth Cloman

15. Birthplace Pennsylvania

16 (a) Informant Mary E. Akehurst

(b) Address 914 Baltic Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location Anne Arundel County, Md.

18 (a) Funeral director George W. Jahnigen

(b) Address 2101 Eastern Avenue

19 (a) OCT 31 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1944 at 9:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 7/18 1938 to 10/30 1944; and that I last saw him alive on 10/29 1944

Immediate cause of death Hypertensive cardio-vascular disease

Duration 6 years 3 mo.

Due to —

Due to —

Other Conditions Coronary Thrombosis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Harry Weibel M. D.

Address 1226 Hanover St. Date signed 10/30/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~G22098~~

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G22098

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 131 S. Culver Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 131 S. Culver Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELEANOR C. KELLY

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife Terance S.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 16, 1871

8. AGE: Years	Months	Days	If less than one day
73	-	13	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas J. Noonan
13. Birthplace Ireland

MOTHER
14. Maiden Name Mary Ann Spriggs
15. Birthplace Ireland

16 (a) Informant Miss Margaret D. Kelly
(b) Address 131 S. Culver Street

17 (a) Burial (b) Date thereof Nov. 2, 194
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul Street

19 (a) Date received by Local Registrar OCT 31 1944 (b) Thurlington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1944 at 10 50 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944 to Oct 28 1944
and that I last saw h[illegible] alive on Oct 28 1944

	Duration
Immediate cause of death: Malignant Lobe of Left Breast and Axilla with Intercurrent	9 Mos
Due to Hemorrhage	
Due to Chr Hypocalcitic	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William R. Straughn M.D.
Address 10 E Biddle Date signed 10/30/44 Kx

G22093

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 D

G22093 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogers Avenue
(c) Hospital or institution Home for Aged M. E. Church
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogers Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANCES ANN BROWN

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	Did not file

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1864

8. AGE: Years	Months	Days	If less than one day
80	1	30	9 hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name William L. Brown
13. Birthplace Scotland

MOTHER
14. Maiden Name Frances Ann Barton
15. Birthplace Baltimore, Maryland

16 (a) Informant Miss Savage
(b) Address 2211 Rogers Avenue

17 (a) Burial (b) Date thereof Nov. 2, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Greenmount
Location Baltimore, Maryland

18 (a) Funeral director William Cook, Inc.
(b) Address 1217 St. Paul St.

19 (a) Date rec'd by Local Reg. OCT 31 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to Oct 29 1944, and that I last saw h[illegible] alive on Oct 29 1944.

	Duration
Immediate cause of death Myocardial degeneration	5 days
Due to Arteriosclerosis	10 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Arthur J. Davis M. D.
Address 800 W 32nd St Date signed 10/30/44

G22100

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22100

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where exact date of birth cannot be obtained, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Franklin Square
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 450 E. 28th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara Free Pasquith

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 7th 1871

8. AGE: Years	Months	Days	If less than one day
73	8	22	hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER
12. Name William Pasquith
13. Birthplace Va

MOTHER
14. Maiden Name Lucy Chitwood
15. Birthplace Va.

16 (a) Informant Mary Cooney
(b) Address 450 E. 28th St

17 (a) Burial (b) Date thereof 11/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Balto. Co. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

19 (a) Date received by local registrar OCT 31 1944 (b) Registrar Huntington Williams M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29th 1944 at 7 45/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 - 1944, to Oct 29 1944, and that I last saw h[illegible] alive on Oct 29 1944.

Immediate cause of death	Duration
Coronary Thrombosis	7 days
Due to arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert K. Mortimer Jr M.D.

Address 2706 St Paul St Date signed 10/30/44

G22.01

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

48B

Registered No. G22.01

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4702 Harford Rd
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3105 Rosalie Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edith Auld Remley

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 2 1889

8. AGE: Years 55 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Harry A Remley Sr
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Ella V Auld
15. Birthplace Baltimore Md

16 (a) Informant Harry A Remley Jr
(b) Address 3105 Rosalie Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Olivet
Location Baltimore Md

18 (a) Funeral director Wilson Corp Inc
(b) Address 1219 E Pont St

19 (a) Filed NOV 31 1944 (Date filed by Registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1944, at 8:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from June 24 1944 to Oct 29 1944 and that I last saw him alive on Oct 28 1944.

Immediate cause of death: Carcinoma of Uterus — Duration 4 years

Due to:

Due to:

Other Conditions: Cerebral Hemorrhage — Duration 6 months
Carcinoma Left Hemiplegia
(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: None

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide? no
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State) none
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury none

23. Signature H. A. Remley M. D.
Address 5706 Harford Road Date signed 10-30-44

(over)

G22:102

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170 C

G22:102

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution:
Mercy Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2548 Lanvale Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Josephine Gelaitis

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Charles
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Lith.
(Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name
13. Birthplace Lith.

MOTHER
14. Maiden Name
15. Birthplace Lith.

16 (a) Informant Charles Gelaitis
(b) Address 2548 Lafayette Ave.

17 (a) Burial (b) Date thereof Oct. 31, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Belair Road

18 (a) Funeral director Joseph Kasmakes Inc.
(b) Address 602 Washington Blvd.

19 (a) OCT 31 1944 (b) Huntingtown, Calvert Co., Md.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1944, at 7:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Crushing of Chest.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-27-44 at 7:35 P. M. 20/2
(b) Where did injury occur? Franklin & Warwick St.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian struck by Auto.

23. Signature W. L. Wollenweber M.D.
Medical Examiner.
Date signed October 28, 1944.

VS 151

G22103

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

Registered No. G22103

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4-W-Highfield Rd.
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 80 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4-W-Highfield Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country —

3 (a) FULL NAME Mary Josephine Boehme

3 (b) If veteran, name war none

3 (c) Social Security Account No. none

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Augustus Boehme

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec-26-1847

8. AGE: Years 96 | Months 10 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name Shalameza Davis
13. Birthplace Maryland

MOTHER
14. Maiden Name Elizabeth Riley
15. Birthplace Virginia

16 (a) Informant Mrs. N. Gettings (daughter)
(b) Address 4-W-Highfield Rd.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 10-31-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Baltimore

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (U. E. WOOLLEN SUC.) 120 W. NORTH AVENUE
(c) (Date rec'd by registrar) OCT 31 1944 (Signature) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1944 7 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to Oct 29 1944. and that I last saw h. alive on Oct 29 1944

Immediate cause of death Hypostatic Congestion — Duration 2 da

Due to Senility

Due to Cerebral Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work? —
(e) Means of injury —

23. Signature Elsie F. Burke M. D.
Address 20 E. Preston Date signed 10/31/44

VS 180

G22104

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95c

Registered No. G22104

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3606 Garrison Blvd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3606 Garrison Blvd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country —

3 (a) FULL NAME Carson N Smith

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug 6 1871

8. AGE: Years	Months	Days	If less than one day
73	2	24	hr. min.

9. Birthplace Baltimore
(Town, county, and state)
10. Usual Occupation Secretary (Retired)
11. Industry or business B & O R R

FATHER
12. Name Joseph N Smith
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Sarah A Brooks
15. Birthplace Baltimore Co Md

16 (a) Informant Miss Etta Smith
(b) Address 3606 Garrison Blvd

17 (a) Burial (b) Date thereof Nov 2-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Baltimore Md

18 (a) Funeral director Dittenhofer
(b) Address 2324 N Charles St

19 (a) (b) Huntington Williams, M.D.
(Date received by Registrar) (year) Registrar

OCT 31 1944
VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1944 at 5 30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1944 to Oct 30 1944, and that I last saw him alive on Oct 30 1944.

Immediate cause of death	Duration
Acute Cardiac dilatation	3 days
Due to Arteriosclerosis etc.	4 yrs
Due to	
Other Conditions —	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Burman Lord M. D.
Address 2200 Garrison Blvd Date signed 10/30/44

G22105

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 469

Registered No. G22105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument St
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2322 Madison Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Rockman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ella

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1871

8. AGE: Years	Months	Days	If less than one day
73			hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Hyman
13. Birthplace Russia

MOTHER
14. Maiden Name Bailey
15. Birthplace Russia.

16 (a) Informant Hyman Rockman
(b) Address

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 10-31-44 (month) (day) (year)
(c) Cemetery or crematory Southern Ave
Location Southern Ave

18 (a) Funeral director Jack Lemaster
(b) Address 1439 E. Baltimore St

19 (a) 10/31/44 (Date rec'd by registrar) (b) Registrar

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1944 at 4 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 30 1944 and that I last saw h alive on Oct 30 1944

Immediate cause of death	Duration
Cardio Vascular-failure	
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions Carcinoma of the Head of the Pancreas	

(Include pregnancy within 3 months of death)

Date of operation Oct 5 & Oct 19 - 1944

Major findings of operation: - Nodular mass in head of Pancreas - Diaphragmatic Hernia

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Brown M. D.
Address Sinai Hospital Date signed 10/31/44

G22106

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22106 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 640 Deepdene Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 43 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City (If outside city or town limits, write RURAL and give town)
(d) Street No. 640 Deepdene Rd (If rural give location)
(e) Citizen of foreign country? — (Yes or No) If yes, name country

3 (a) FULL NAME Emma Francis Rice

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife William Rice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18-1848

8. AGE: Years 96 | Months 6 | Days 10 | If less than one day hr. min.

9. Birthplace A.A.Co. Md (Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER 12. Name — Brown
13. Birthplace unknown

MOTHER 14. Maiden Name Mary Hoye
15. Birthplace unknown

16 (a) Informant Wm Rice
(b) Address 640 Deepdene Rd

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31-1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Frank H Seitz
(b) Address 814 E 36 St.

(a) Oct 31 1944 Huntington Williams M.D. (Local registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28 1944, at 10:08 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 27 1944 to Oct 28 1944, and that I last saw h[er] alive on Oct 28 1944

Immediate cause of death	Duration
Coma Myocarditis	5 hrs ?
Due to	
Due to	
Other Conditions Arteriosclerosis	1 month

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. W. Bishop M. D.
Address 501 Sheridan Ave Date signed Oct 29-44

G22107 4

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22107

Registered No.

JO #81076

MARGIN RESERVED FOR BINDING.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1yrs 6mos. 7days

(e) Length of stay in Baltimore (yrs., mos., or days) 21 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 1707 Etting St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lee C. Wade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widowed

6 (b) Name of husband or wife Bertha (d)

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20, 1886

8. AGE: Years	Months	Days	If less than one day
58	5	7	hr. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER: 12. Name Elizah King

13. Birthplace Georgia

MOTHER: 14. Maiden Name Mattie Taylor

15. Birthplace Georgia

16 (a) Informant Records, Baltimore City Hosp.

(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Zion

Location Balto. Co.

18 (a) Funeral director Samuel M. Shane & Son

(b) Address 628 N. Eutaw St.

OCT 31 1944 (Date received by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1944, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 4/20 19 43 to 10/27 19 44, and that I last saw him alive on 10/27 19 44

Immediate cause of death Subarachnoid Hemorrhage — Duration

Due to Rupture of Cerebral Artery — Duration Approx. 5 days

Due to

Other Conditions Arteriosclerotic Heart Disease.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Massive Subarachnoid Hemorrhage.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. B. Reese Jr. M. D.

Address City Hosp. Date signed 10/30

PHYSICIAN

Underline the cause to which death should be charged statistically.

G22:08

10 462809

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22:08

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 Englewood Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret Lillie Brogden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3 1865

8. AGE: Years: 79 | Months: 2 | Days: 27 | If less than one day: hr. min.

9. Birthplace Md -
(Town, county, and state)

10. Usual Occupation Social Worker

11. Industry or business

FATHER
12. Name James Brogden
13. Birthplace Md -

MOTHER
14. Maiden Name Ella Gittinger
15. Birthplace Md -

16 (a) Informant Records -
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 1944 (month) (day) (year)
(c) Cemetery or crematory Trinity Church
Location Long Green Md

18 (a) Funeral director Henry W. Stephens & Sons
(b) Address McCurdy & Pachard Sts

19 (a) (Signature of local registrar) (b) Huntington Williams, M.D.

OCT 31 1944

VS 150

MEDICAL CERTIFICATION 26

20. DATE OF DEATH Oct 30, 1944 at 10 a.m. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 1944 to Oct 30 1944 and that I last saw her alive on Oct 30 1944

Immediate cause of death: Cardiac Failure
Due to: Renal Insufficiency
Due to: Arteriosclerosis, generalized
Due to: Arteriosclerotic Heart Disease
Other Conditions: Hernia
(Include pregnancy within 3 months of death)

Duration: 8 wks; 10-15 yrs

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
Means of injury

23. Signature [illegible] M.D.
Address Johns Hopkins Date signed 10/30/44

G22109 2316 Frederick Ave

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

94a ✓ Registered No. G22109

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1805 ASBURTON ST.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1805 ASBURTON ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN L. DUERR

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213-05-6546

4. Sex: MALE | 5. Color or race: WHITE | 6 (a) Single, married, widowed, or divorced: MARRIED

6 (b) Name of husband or wife: DOROTHY C. DUERR

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JULY 29 1887

8. AGE: Years 57 | Months 2 | Days 29 | If less than one day hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)

10. Usual Occupation OIL GAGER

11. Industry or business CONN. OIL CO.

FATHER
12. Name JOSEPH DUERR
13. Birthplace BALTO.

MOTHER
14. Maiden Name PAULINE EVERHARDT
15. Birthplace GERMANY

16 (a) Informant DOROTHY DUERR (WIFE)
(b) Address 1805 ASBURTON ST.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 31/44 (month) (day) (year)
(c) Cemetery or crematory MEADOWRIDGE
Location WASHINGTON BLVD.

18 (a) Funeral director Lilly and Geiler, Inc.
(b) Address 403 S. WOLFE ST.

19 (Date received by local registrar) OCT 31 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION AM.

20. DATE OF DEATH OCT. 28 1944 at 4/30M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 28 1944 and that I last saw him alive on Oct 28 1944

Immediate cause of death: Repeated Myocardial Infarct — Duration: 8 MOS

Due to: Arteriosclerosis — 7

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation?
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide?
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. J. Glaser
Address 326 Forest St. Date signed 10/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARIE C. BAST

G22110

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

G22110 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 11 S. Janney Street
(c) Hospital or institution:
Church Home and Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18 days
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 11 S. Janney Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Marie C. Bast

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Mr. Martin Bast
6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.): Sept 29-1900

8. AGE: Years 44 | Months 1 | Days 1 | If less than one day: hr. min.

9. Birthplace: Baltimore Md
(Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Mr. John Buchheimer
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Margaret Nelter
15. Birthplace: Baltimore Md

16 (a) Informant: Martin L. Bast
(b) Address: 11 S. Janney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10-2-44 (month) (day) (year)
(c) Cemetery or crematory: Sacred Heart
Location: Gerynn Hill Road

18 (a) Funeral director: Lilly and Zeiler Inc
(b) Address: 403 S. Wolfe St.

19 (a) Date received by Registrar: OCT 31 1944 (b) Registrar: Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1944 at 4:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 11 1944 to Oct 29 1944, and that I last saw her alive on Oct 28 1944.

Immediate cause of death: Coronary occlusion — Duration:

Due to: generalized arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Clarke Howes, Jr. M. D.
Address: Church Home Hospital Date signed: 10/29/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22111

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93 V

Registered No. G22111

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4015 Falls Road.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4015 Falls Road.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joshua Jones.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	widower.

6 (b) Name of husband or wife Sarah M. Jones

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 12, 1850

8. AGE: Years	Months	Days	If less than one day
94	7	17	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Retired Foreman

11. Industry or business Poole Foundry.

FATHER
12. Name Andrew Jones
13. Birthplace Maryland.

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown.

16 (a) Informant Mrs. Clarence Miller.
(b) Address 4015 Falls Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville,

18 (a) Funeral director Chenoweth & Donovan
(b) Address 3615-17 Chestnut Ave.

19 (a) [illegible] (b) Huntingtown Maryland

OCT 31 1944
VS No 1

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29, 1944, at 4 40/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1 1944, to Oct. 29 1944 and that I last saw h[illegible] alive on Oct. 25 1944

Immediate cause of death — Duration

Congestive Heart Failure

Due to Arteriosclerotic C.V. Disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas. Glassman

Address 4037 Falls Rd. Date signed 10/21/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22112

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G22112

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 68 days
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4108 Fernhill Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) **FULL NAME** Anna N. Kay

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married (widow)

6 (b) Name of husband or wife George A. Kay, Sr.
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 10, 866

8. AGE: Years	Months	Days	If less than one day
78	1	19	..... hr. ..... min.

9. Birthplace Michigan
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John Nichols
13. Birthplace ----- Md.

MOTHER
14. Maiden Name ----- Anna ?
15. Birthplace ----- Mich.

16 (a) Informant Mr. George Kay
(b) Address 4108 Fernhill Ave., City #15

17 (a) Burial (b) Date thereof 11/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) OCT 31 1944 Huntington Williams M.D.
(Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1944, at 7455 M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1 1944, to October 29 1944, and that I last saw h.s.r. alive on October 29 1944.

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arteriosclerotic heart disease	2 y.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? .....
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? .....
(Specify type of place)
(e) Means of injury .....

23. Signature Jas. W. Musgrave Jr. M.D.
Address 338 E. University Pkwy. Date signed 10/29/44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22113

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22113

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1818 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 ✓
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1818 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME CATHERINE T. FREEDENBURG

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Jacob
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 14, 1871

8. AGE: Years	Months	Days	If less than one day
73	9	13	hr. min.

9. Birthplace Balto., Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Harry Osbourn
13. Birthplace Baltimore

MOTHER
14. Maiden Name Catherine Phillips
15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Jacob Freedenburg
(b) Address 1818 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/30/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Date received by Local Registrar OCT 31 1944 (b) Huntington Williams, M.D.

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1944 at 8:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 11 19XX to Oct 27 19XX, and that I last saw h[illegible] alive on Oct 27 19XX.

	Duration
Immediate cause of death Cardio Vascular Disease	6 mo's
Due to Broken Compensation	2 mo's
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey, M.D.
Address 1928 Pa. Ave. Date signed 10/30/44

G22114 G22114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

94a

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 West North Ave 24 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Thomas Worthington Rodgers

If U. S. Veteran specify WAR

(a) Residence: No. 1806 West North Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White American	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, year) August 27, 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	1	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Merchant-retired

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Own grocery

10. Date deceased last worked at this occupation (month and year) 1940

11. Total time (years) spent in this occupation 15 yrs.

12. BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

FATHER

13. NAME John Sharp Rodgers

14. BIRTHPLACE (city or town) (State or country) Baltimore Maryland

MOTHER

15. MAIDEN NAME Margaret Olivia Frybarger

16. BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

17. INFORMANT Mrs. Edward N. Foley (Sister)
(Address) 12 East 73rd St

18. BURIAL, CREMATION, OR REMOVAL
Place Mt. Olive, Randallstown Date 10/31/44 19

19. UNDERTAKER Wm. J. TICKNER & SONS
(Address) Balto., Md.

20. OCT 31 1944 19 Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) October 28, 1944

22. I HEREBY CERTIFY, That I attended deceased from Dec 1939 to Oct 28 1944

I last saw him alive on October 15, 1944. Death is said to have occurred on the date stated above, at 1 A m. (Effect.)

The principal cause of death and related causes of importance were as follows:

	Date of onset
Coronary Occlusion (History)	10/27/44
Other contributory causes of importance: Arteriosclerosis (Senile)	1940

Was an operation performed? No Date of

For what disease or injury?

Name of operation —

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury, 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? Not If so, specify

(Signed) W. Sterling Hargrave M. D.
(Address) 2 W. Medical Arts Building

For P.H.L. Rollenhagen, by Howard J. Morris, M.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. Every item information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See instructions on back of certificate.

G22115

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

Registered No. G22115

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5315 Springlake Way
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5315 Springlake Way (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE LUCETTA TSCHUDY

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Stephen C. Tschudy
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1865

8. AGE: Years 79 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual Occupation: none

11. Industry or business

FATHER
12. Name: Howard E. D. Stone
13. Birthplace: Mass.

MOTHER
14. Maiden Name: Eliza Lamb
15. Birthplace: Md.

16 (a) Informant: Mrs. Edna Webster
(b) Address: 5315 Springlake Way

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. ECKNER & SONS
(b) Address: Balto., Md.

19 OCT 31 1944 (Date received by Local Registrar) (b) Huntington Williamsburg, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct. 29 19 44 at 7:30PM

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 19 44 to Oct. 29 1944, and that I last saw her alive on Oct. 29 19 44.

Immediate cause of death: Carcinoma Colon — Duration: 6mo.

Due to: Fractured Pelvis — 10-1944

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide: Accident 27/12
(b) Date of occurrence: October 29 1944 M
(c) Where did injury occur? 5315 Springlake Way (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? at home While at work? (Specify type of place)
(e) Means of injury: Fall to floor

23. Signature: [signature]
Address: 617 W. 40th St. Date signed 10/30/44 M. D.

For Dr. H. B. Tschudy, by Howard L. Anderson, M.D.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22116

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

G22116 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2010 Eastern ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2010 Eastern ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Spencer Gable

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Not Known

8. AGE: Years About 70 | Months | Days | If less than one day hr. min.

9. Birthplace Penna.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name ?
13. Birthplace ?

MOTHER 14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Anna Redd
(b) Address 2010 Eastern Ave

17 (a) Burial (b) Date thereof Nov. 1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave

18 (a) Funeral director Wm. J. Fialkowski
(b) Address 2007 Eastern Ave

19 OCT 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944 at 12:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 5 1944 to Oct 1944 and that I last saw him alive on Oct 29 1944.

Immediate cause of death Coronary Thrombosis — Duration 10/27/44

Due to Chr. Myocard. d.s — 1/1/44

Due to Arteriosclerosis — 1940

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William J. Bauer M. D.
Address 501 N Kenwood Ave Date signed Oct 31 1944

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G22117 345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G22117

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 127 W. West
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 127 W. West
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Albert Carey
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male
5. Color or race: C
6 (a) Single, married, widowed, or divorced: Child
6 (b) Name of husband or wife: Child
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Feb 4, 1944
8. AGE: Years | Months 8 | Days 24 25 | If less than one day hr. min.
9. Birthplace West Point Va
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Albert Carey
13. Birthplace Va

MOTHER
14. Maiden Name Bu Christan
15. Birthplace Va

16 (a) Informant Beulah Carey (m)
(b) Address 127 W West St

17 (a) Removal (b) Date thereof 10/31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory West Point
Location Virginia
18 (a) Funeral director Josiah L. Brown & Son
(b) Address 10 & W Montgomery St

OCT 31 1944 Huntington W. Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/44 19 . at M

21. I certify that death occurred on the date above stated, that I attended deceased from 10/27 19 44 to 10/29 19 44.
and that I last saw h alive on 10/29 19 44.
Immediate cause of death Coronary Thrombosis — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible] M. D.
Address [illegible] Date signed 10/31/44

G22118

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G22118

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland 1616 Riggs ave
(b) Street address Balto Md
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yr

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 1616 Riggs ave (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elmora Johnson Sutton
3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col.	Married

6 (b) Name of husband or wife Laurence
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug - 1907

8. AGE: Years	Months	Days	If less than one day
37	2		hr. min.

9. Birthplace Va
10. Usual Occupation Domestic (Town, county, and state)
11. Industry or business

FATHER
12. Name Jennie Johnson
13. Birthplace Va.

MOTHER
14. Maiden Name Annie Brooks
15. Birthplace Va

16 (a) Informant Laurence Sutton
(b) Address 1616 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date of [illegible] 11/1/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md.

18 (a) Funeral director Reg. H. Kelson
(b) Address 1303 Pennsylvania Ave.

NOV 3 1944 (Huntington Williams, M.D. Registrar)
(Date rec'd by Registrar)

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1944, at 6:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Oct 29 1944 and that I last saw h[illegible] alive on 10-25-1944

Immediate cause of death Cardiac Dilatation — Duration

Due to Myocarditis, Gallstones. — Hypotension

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm R Boyton M.D.
Address 1135 Eutaw Date signed 10/30/44

G22119

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 51B

G22119 Registered No.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1310 N Carey St
(c) Hospital or institution: 15

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 mo
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1310 Carey St
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Kyler

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Widowed

6 (b) Name of husband or wife Beatrice Kyler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? 1890

8. AGE: Years	Months	Days	If less than one day
54			hr. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Henry Kyler
13. Birthplace Md.

MOTHER
14. Maiden Name Victoria Gant
15. Birthplace Md.

16 (a) Informant Dora Kyler
(b) Address 1310 N Carey St

17 (a) Burial (b) Date thereof 11/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Huntingtown
Location Calvert Co. Md

18 (a) Funeral director Edg. W. Kelso
(b) Address 1303 Presstman St.

OCT 31 1944 (b) Huntingtown Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 28 19XX, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 19XX to Oct 28 19XX; and that I last saw he alive on Oct 26 19XX

Immediate cause of death	Duration
Carcinoma of Prostate Gland	6 mo's
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature William Frey
Address 1928 Pa Ave Date signed 10/30/XX

G22120

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 937

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1613 Rutland ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Amelia Collins

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Albert E. Collins

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Aug. 11, 1886

8. AGE: Years	Months	Days	If less than one day
58	2	16	hr. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual Occupation: house wife

11. Industry or business

FATHER
12. Name: John Miller
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Amelia Born
15. Birthplace: Baltimore Md.

16 (a) Informant: Albert E. Collins
(b) Address: 1613 Rutland Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 31/44 (month) (day) (year)
(c) Cemetery or crematory: Meadowridge Mem.
Location: Washington Blvd

18 (a) Funeral director: Clarence F. Hoffmann
(b) Address: 1639 N. Broadway.

OCT 31 1944 (Date received by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1944 at 11 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Chronic Myocardial degeneration

Due to

Other Conditions Hypertension

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 10-27-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G22121

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G22121

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1801 E. Madison St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State ..... (b) County .....
(c) City or town Baltimore City (If outside city or town limits, write RURAL and name town)
(d) Street No. 1801 E. Madison St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country .....

3 (a) FULL NAME Robert Taylor
3 (b) If veteran, name war .....
3 (c) Social Security Account No. 216-15-0494

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Colored	Married

6 (b) Name of husband or wife Corethia
6 (c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Feb. 1903

8. AGE: Years	Months	Days	If less than one day
40	8		hr. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation Salesman
11. Industry or business

FATHER
12. Name William H. Taylor
13. Birthplace Amelia Co Va

MOTHER
14. Maiden Name Catherine Reed
15. Birthplace Amelia Co. Va.

16 (a) Informant Corethia Taylor
(b) Address 1801 E. Madison St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2-1944
(c) Cemetery or crematory Mt Calvary Cemetery
Location Baltimore Md
18 (a) Funeral director R. Hugh Wellington
(b) Address 15-15 E. Eager St
OCT 31 1944 (Date received by Registrar) (b) Signature Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

19. DATE OF DEATH Oct. 27 1944 at 10:45 A.M.
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1944 to Oct 27 1944 and that I last saw h[illegible] alive on Oct 27 1944.
Immediate cause of death Valvular Heart disease — Duration .....
Due to .....
Due to .....
Other Conditions .....
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
Did injury occur about home, on farm, industrial place, in public place? ..... (Specify type of place) While at work? .....
(e) Means of injury .....
23. Signature J. Edward Fisher
Address 1622 W. Lanvale St. Oct 30 '44

G22122

BALTIMORE CITY HEALTH DEPARTMENT

G22122

CERTIFICATE OF DEATH 1311a

Registered No. (over)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Rutland
(c) Hospital or institution: Sinai Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2342 Eutaw Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Ricka F. Gans (or Rita Gans)

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Wm. I. Gans
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 31 1865

8. AGE: Years	Months	Days	If less than one day
79	6	20	hr. min.

9. Birthplace N.Y.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Henry Frankenstein
13. Birthplace Germany

MOTHER
14. Maiden Name Fannie Wolzinger
15. Birthplace Germany

16 (a) Informant Mr. M. Burgunder
(b) Address 2342 Eutaw Place

17 (a) Burial (b) Date thereof 11/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balt. Md.

18 (a) Funeral director Harris Sons & Levy
(b) Address 1702 Eutaw Place

19 (Date received by registrar) Huntington Williams M.D.
OCT 31 1944
VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1944, at 8:07 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1944 to 10/30 1944, and that I last saw h. alive on 10/30 1944

Immediate cause of death	Duration
Cardiac failure	
Renal failure	
Due to Hypertension	
Due to Chronic glomerulitis?	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: Not proven

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Henry H. Herman
Address Sinai Hospital Date signed 10/31/44

Herman

G22123

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22123

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1625 S. Charles St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 S. Charles St. (If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME George H. Leibold

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Laura V. Leibold
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Jan. 4 1872

8. AGE: Years 72 | Months 9 | Days 26 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Clerk in Courthouse

11. Industry or business Court of Common Pleas

FATHER 12. Name John G. Leibold
13. Birthplace Md.

MOTHER 14. Maiden Name Louise (?)
15. Birthplace Ger.

16 (a) Informant Mrs. Laura V. Leibold (wife)
(b) Address 1625 S. Charles St (30)

17 (a) Burial — (b) Date thereof Nov 2 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood-Cem
Location Balto. 14, Md.

18 (a) Funeral director G. Howard Evans
(b) Address 1400 E. Charles St. (30)

19 OCT 31 1944 (b) Huntington Williams, M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION 12:00

20. DATE OF DEATH Oct. 30, 1944 at noon M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1944 Oct 30 1944
and that I last saw ~~him~~ alive on Oct 29 1944

Immediate cause of death Myocardial Insufficiency — Duration

Due to —

Due to —

Other Conditions Myocarditis & Arteriosclerosis
(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at ... M
(c) Where did injury occur? ... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ... While at work? ... (Specify type of place)
(e) Means of injury —

23. Signature John A. Schemmit
Address 1357 S. Charles St Date signed 10/30/44 M. D.

G22124

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22124

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1224 Hanover
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1224 Hanover St (Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary H. Klingenberg

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife James F. Klingenberg
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 15, 1880

8. AGE: Years	Months	Days	If less than one day
63	11	14	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Christian F. Schwemm
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Gardner
15. Birthplace Germany

16 (a) Informant Miss Elizabeth Klingenberg
(b) Address 1224 Hanover St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1 1944 (month) (day) (year)
(c) Cemetery or crematory Western Cem.
Location Balto. Md.

18 (a) Funeral director O'Edward Evans
(b) Address 1400 W. Chamberlain
OCT 31 1944 (c) Huntington Williams M.D.
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29, 1944 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 4/27 1943, to 10/29 1944, and that I last saw h[illegible] alive on 10/28 1944.

Immediate cause of death Coronary thrombosis — Duration 4 days
Due to —
Due to —
Other Conditions Hypertensive cardiovascular renal disease — Duration typewritten

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
If autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Harry Weibel
Address 1226 Hanover St Date signed 10/30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully checked for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR READING

G22125

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193a

G22125 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1740 Ashland Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 d
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1740 Ashland Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harriett Howard

3 (b) If veteran, name war | 3 (c) Social Security Account No

4. Sex F. | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joseph Howard

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 16th 1872

8. AGE: Years 72 | Months 2 | Days 10 | If less than one day: hr. min.

9. Birthplace Eastern Shore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Joseph Smith
13. Birthplace Md

MOTHER
14. Maiden Name Amelia Hunt
15. Birthplace Va.

16 (a) Informant Amelia Brown
(b) Address 1740 Ashland Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 31st 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Zion
Location Balto, Co. Md

18 (a) Funeral director Belmont Higgins & Knight
(b) Address 731 Druid Park

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

OCT 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26 1944 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 12 1944, to Oct. 26 1944 and that I last saw h[illegible] alive on Oct. 26 1944.

Immediate cause of death Pulmonary edema
Acute myocarditis — Duration 2 Day 1 Dau

Due to Cerebral Arteriosclerosis — 44 Days

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. LeRoy Dorsey M. D.
Address 1420 E. Chase Date signed 10-30-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G22126

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13B

G22126 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 525 N. Dallas Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give county)
(d) Street No. 525 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alonzo Brown

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 11, 1871

8. AGE: Years 73 | Months 2 | Days 16 | If less than one day: hr. min.

9. Birthplace Greensboro N. C.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Benjamin Brown
13. Birthplace D. C.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Mrs. Annie Brown
(b) Address 525 N. Dallas Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director Elroy O. Walston

(b) Address Brantley Av

19 (a) OCT 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 27, 1944, at 6:30 P. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Pulmonary tuberculosis.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Henry L. Wollenweber M.D.
Medical Examiner.

Date signed October 28, 1944.

Rev. Howard J. Walker, M.D.

22127

AB-60525

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22127

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8days

(e) Length of stay in Baltimore (yrs., mos., or days) 38 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 909 Bennett Place
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Patience Lee

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife George Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- (58?)

8. AGE: Years	Months	Days	If less than one day
58 ?	?	?	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Baltimore City Hospitals(Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11/2/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 10000 Reisterstown

19 OCT 31 1944 (b) Huntington Williamsport, Md.
(Date received by Local Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29 1944, at 3:45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21 1944, to 10/29 1944, and that I last saw her alive on 10/29 1944

Immediate cause of death	Duration
Cerebral embolus	
Due to myocardial infarction	
2 mural thrombi	
Due to HBP	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature C. Lowry, Jr. M.

Address City Hosp. Date signed 10/30

G22128

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 777

G22128 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 701 Bureau St.
(c) Hospital or institution: Baltimore City Jail
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3'
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 Lloyd St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Henry Sills

3 (b) If veteran, name war ?

3 (c) Social Security Account No. ?

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	married

6 (b) Name of ~~husband or~~ wife Mamie Sills

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? 1899

8. AGE: Years	Months	Days	If less than one day
45 yrs			hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business ?

MOTHER / FATHER

12. Name ?

13. Birthplace ?

14. Maiden Name ?

15. Birthplace ?

16 (a) Informant Dr. Thomas J. Mills

(b) Address Balto City Jail.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 3 (day) 44 (year)

(c) Cemetery or crematory Mt Calvary

Location :

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley ave.

(Date received by Local Registrar) OCT 31 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/27/1944, at 7:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/21/44 to 10/27/44 and that I last saw h alive on 10/26/44

Immediate cause of death Acute Cardiac Dilatation — Duration 1½ hrs

Due to Chronic alcoholism — 1 years

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Thomas J. Mills

Address Balto City Jail Date signed 10/31/44 M. D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22129

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G22129 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1106 Low St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Dundalk Box 67
(If outside city or town limits, write RURAL and give town)
(d) Street No. Wise ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude G. Briggs

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife James O. Briggs | 6 (c) If alive, give age

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Turner Station, Md (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER
12. Name Thomas Grundy
13. Birthplace Va.

MOTHER
14. Maiden Name Henrietta Fortune
15. Birthplace Md.

16 (a) Informant James O. Briggs
(b) Address Wise ave - Box 67

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/31/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomfield Ave

19 (Date received by registrar) OCT 31 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

10/26/44 10 A.M.

20. DATE OF DEATH Oct 26 1944

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 1944 to Oct 26 1944, and that I last saw h[illegible] alive on Oct 26 1944

Immediate cause of death: Cardio-renal disease — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M. D.
Address 1422 E. Chase St. Date signed 10-30-44

G22130

AB-90309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G22130 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 4 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County ✓
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 107 N. Carey St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William A. Bowers

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife Brazelia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 22- 1907

8. AGE: Years	Months	Days	If less than one day
37	9	8	hr. min.

9. Birthplace Pa. (Town, county, and state)

10. Usual Occupation Shipfitter

11. Industry or business

FATHER
12. Name Arthur Bowers
13. Birthplace Martinsburg W. Va

MOTHER
14. Maiden Name Celia
15. Birthplace Ga.

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Green Hill Cem
Location Martinsburg, West Va.

18 (a) Funeral director John J. Conway, Sons
(b) Address 901-03 Hollins Street

19 OCT 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30- 1944, at 4.35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Oct 30 1944, and that I last saw h e alive on Oct 30 1944.

Immediate cause of death	Duration
Due to Heart failure	24 hr.
Due to Pulmonary Tuberculosis	months
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Findings

For columns F & G of the

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Luis Dalman M. D.
Address Baltimore City Hospital Date signed 10/31/44
Luis Dalman

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22131

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1477

G22131 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3208 Barclay St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3208 Barclay St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Joseph Becker

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1882

8. AGE: Years 62 | Months – | Days – | If less than one day hr. min.

9. Birthplace Baltimore Md –
(Town, county, and state)

10. Usual Occupation Traffic Mgr.

11. Industry or business Baltimore City

FATHER
12. Name Charles Becker
13. Birthplace Germany

MOTHER
14. Maiden Name Anna C Kerrigan
15. Birthplace Ireland

16 (a) Informant Mrs John J. Becker
(b) Address 3208 Barclay St

17 (a) Burial (b) Date thereof 11-2-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location –

18 (a) Funeral director Mary M. Wiedefeld
(b) Address 501 E 22nd St

19 OCT 31 1944 (b) Huntington Williams
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 12th 1944 to Oct 30 1944 and that I last saw him alive on Oct 30 1944

Immediate cause of death	Duration
Carcinoma of Liver & Lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. Ephraim M. D.

Address 4436 Wabash Ave Date signed 10/31/44

M. Ephraim

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22132

JL - 31961

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22132

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 - 7 - 3

(e) Length of stay in Baltimore (yrs., mos., or days) 12 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. No Home (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Isaac Washington

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Widowed

6 (b) Name of husband or wife Rosa Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1890

8. AGE: Years	Months	Days	If less than one day
53	11	7	hr. min.

9. Birthplace La. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name Isaac Washington

13. Birthplace La.

MOTHER

14. Maiden Name Emily ?

15. Birthplace La.

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 10/31/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location Edmondson Ave. & Hilton Rd Baltimore Md

18 (a) Funeral director John F. Lafayette

(b) Address 1911 Fifth St. W.

OCT 31 1944

(a) (Registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1944, at 25 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1944, to 10-29 1944, and that I last saw him alive on 10-29 1944.

Immediate cause of death	Duration
Diabetic acidosis	24 hrs.
Due to	
Due to	
Other Conditions arteriosclerotic heart disease.	?

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: No post

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. N. Phillipp M. D.

Address Balt. City Hosp Date signed 10-30-44

G22133

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22133

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6 N. Chapel St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6-14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6 N. Chapel St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Peal Deckret (or) Dickret

3 (b) If veteran, name war No

3 (c) Social Security Account No. None

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Josephine C. Remkin

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1888

8. AGE: Years 55 | Months 11 | Days 2 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name John F. Deckret
13. Birthplace France

MOTHER
14. Maiden Name Mary R. Probst
15. Birthplace Baltimore, Md.

16 (a) Informant Josephine C. Remkin
(b) Address 6 N. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 10/2/44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. V. E. Doppelt Sons
(b) Address Lombard & Aisquith St.

19 (a) 10 1944 (b) Registrar
(Date received by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1944 at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1 1944 to Oct. 29 1944
and that I last saw him alive on Oct. 29 1944

Immediate cause of death Coronary Thrombosis — Duration 4 mos.
Due to Angina Pectoris
Coronary Arteriosclerosis
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature [illegible]
Address 700 E Pratt Date signed 10/29/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.
MARGIN RESERVED FOR BINDING

22134

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E

Registered No. 22134

MARYLAND RESERVED FOR READING

Every item of information should be carefully supplied. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 228 da.
(e) Length of stay in Baltimore (yrs., mos., or days) 8 Mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County
(c) City or town Morgan Town
(If outside city or town limits, write RURAL and give town)
(d) Street No. Box 96 Route 6
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Talindo Bonfili

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Perina Bonfili
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-21-89

8. AGE: Years	Months	Days	If less than one day
55 54	8	10	hr. min.

9. Birthplace ITALY (Town, county, and state)
10. Usual Occupation Coal miner.
11. Industry or business

FATHER
12. Name ?
13. Birthplace

MOTHER
14. Maiden Name ?
15. Birthplace

16 (a) Informant ?
(b) Address

17 (a) Burial (b) Date thereof 11-3-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory
Location Morgantown W Va

18 (a) Funeral director A. Lee Oder
(b) Address 4644 York Rd.

(c) Date received by Local Registrar OCT 31 1944 (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. **DATE OF DEATH** Oct 31 1944, at 1 00 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 3-13 1944, to 10-31 1944, and that I last saw h.IM alive on 10-31 1944

Immediate cause of death Cardio-Respiratory failure
Due to Chondromyxosarcoma
Due to
Other Conditions Possible Tuberculosis Cav.
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence July, 1943 at M
(c) Where did injury occur? Coal mine
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Industrial While at work? Yes
(Specify kind of place)
(e) Means of injury Loose hit him on leg
23. Signature G. B. McFadden
Address St Joseph's Hosp. Date signed 10/31/44

Approved by Howard L. Mercein, M.D.

G22135

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 832a

Registered No. G22135

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 15 N. Carey St
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) —
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 15 N. Carey St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles B Waddey.

3 (b) If veteran, name war —

3 (c) Social Security Account No. 220-05-4520

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Emmanuel Reno

6 (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) Feb 5. 1885

8. AGE: Years 59. Months 9 8 Days 1 If less than one day hr. min.

9. Birthplace Northumberland Co Va
(Town, county, and state)

10. Usual Occupation Estate Keeper

11. Industry or business Shipyard

FATHER — 12. Name Wm. B. Waddey.
13. Birthplace Va

MOTHER — 14. Maiden Name Mary Elizabeth Ford
15. Birthplace Va

16 (a) Informant Mrs. Chas B. Waddey
(b) Address 15 N. Carey St.

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory London Park
Location Hyattsville Md

18 (a) Funeral director Thos J. Kenny
(b) Address Hollins & Belnord

OCT 31 1944 (b) Huntington Williamsport
(Registrar) (Date)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 1944, at 11 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1944 to Oct 29 1944, and that I last saw him alive on Oct 29 1944

Immediate cause of death: Cerebral Hemorrhage — Duration: 4 days

Due to: Hypertension

Due to: Arterial Sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas A Reber M. D.

Address 2145 W Belvedere Date signed

G22136

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22136 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Laynes Ave & Dukeland St.
(c) Hospital or institution: West Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 28 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 840 N. Fayette St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Floyd Hoskins

3 (b) If veteran, name war

3 (c) Social Security Account No. [redacted]

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	—

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 12. 1943

8. AGE: Years	Months	Days	If less than one day
	10	18	hr. min.

9. Birthplace Mc Kee Kentucky (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Frederick Hoskins
13. Birthplace Asher, Kentucky

MOTHER
14. Maiden Name Alice E. Wynn
15. Birthplace Mc Kee Kentucky

16 (a) Informant Fred. Hoskins
(b) Address 840 N. Fayette St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory
Location Mc Kee Ky Kentucky

18 (a) Funeral director Jas J. Conroy
(b) Address Collins & Gilmor

19 (a) Registrar Huntington Williams M.D. Registrar

OCT 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1944, at 12:05 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/2 1944 to 10/30 1944, and that I last saw h. alive on 10/30 1944.

Immediate cause of death	Duration
Asphixiation of vomitus	
Due to Malnutrition	
Secondary Anaemia	
Due to Cancer	
Other Conditions Rickets	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide 18/1
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daisy L. Taylor M. D.
Address WBGA Date signed 10/30/44

G22137

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registration No. G22137

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5712 Roland Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) 39 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County ------
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5712 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Sister Mary Claude Hassett

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife ---------
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) May 24, 1868

8. AGE: Years	Months	Days	If less than one day
76	5	6 7	---hr. ---min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation Religious
11. Industry or business --------

FATHER
12. Name David Hassett
13. Birthplace Ireland

MOTHER
14. Maiden Name Alice Moher
15. Birthplace Ireland

16 (a) Informant Convent of Visitation Records
(b) Address 5712 Roland Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

OCT 31 1944 (a) (Registered by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944 at 5-30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1944 to Oct 1944 and that I last saw her alive on Oct 29 19 44

Immediate cause of death

	Duration
Carcinoma of Stomach	
Due to	6 mo.
Due to	
Other Conditions Arteriosclerosis Senile	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Frank J. Bevacqua M. D.
Address 3047 St Paul St Date signed 10/31/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G22138

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G22138

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: University Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1124 N. Calhoun St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas J. Sheppard

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Susie

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 13, 1895

8. AGE: Years 49 | Months 3 | Days 15 | If less than one day ... hr. ... min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Thomas Sheppard
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Robinson
15. Birthplace Md.

16 (a) Informant Susie Sheppard
(b) Address 1149 N. Calhoun St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month, day, year)
(c) Cemetery or crematory St Peters
Location Md

18 (a) Funeral director Geo. D. Kelson
(b) Address 1303 Pennsylvania Ave

19 (a) OCT 31 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1944, at 2 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Intracranial hemorrhage

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-29-44 8:20 P.M. 25/3
(b) Where did injury occur In front of 3326 Annapolis Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No.
(d) Means of injury Pedestrian, struck by Auto.

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.
Date signed October 31, 1944.

G22139

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 927

G22139 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR HEADING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1312 Linden Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1312 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Arthur W. Boucher

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b). Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 Months Days If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown

FATHER 13. Birthplace "

MOTHER 14. Maiden Name "

MOTHER 15. Birthplace "

16 (a) Informant J. P. Draughy

(b) Address 1312 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3 44 (month) (day) (year)

(c) Cemetery or Crematory

Location Westernport. Md.

18 (a) Funeral director John A. Hagen

(b) Address 600 E. Balto. St.

19 (a) (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

OCT 31 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944, at M.

21. I certify that death occurred on the date above stated; that I attended deceased from Apr 1943 to Oct 31 1944 and that I last saw him alive on 10/29 1944.

Immediate cause of death Cl. Valve. Heart annul. Fibrillation — Duration 14 days

Due to arteriosclerosis — —

Due to — —

Other Conditions Bronchiectasis — 5 yrs

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Edward Hoff M.D.

Address 2040 Clarke Date signed 10/31/44

G22140

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

Registered No. G22140

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2 Blythewood Road
(c) Hospital or institution: none
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County none
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2 Blythewood Road
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Paul M. Burnett

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Elizabeth Jackson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 | 18 | 1866

8. AGE: Years 77 | Months 9 10 | Days 12 | If less than one day ____hr. ____min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual Occupation: Insurance Broker & Banker

11. Industry or business

FATHER
12. Name: William T. Burnett
13. Birthplace: Md.

MOTHER
14. Maiden Name: Amelia M. Simmont
15. Birthplace: Md.

16 (a) Informant: Mrs. Elizabeth J. Burnett
(b) Address: 2 Blythewood Road

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/1/44 (month) (day) (year)
(c) Crematory: Loudon Park
Location: 3801 Frederick Ave.

18 (a) Funeral director: John O. Mitchell & Sons
(b) Address: 1900 Eutaw Place

19 (a) Date filed by registrar: OCT 31 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from June 30 1944 to Oct. 30 1944 and that I last saw h[illegible] alive on Oct. 30 1944.

	Duration
Immediate cause of death: Heart failure	6 mos.
Due to: Arteria. sclerotic Heart disease	15 yrs.
Due to: arteriolosclerosis & pellagra	4 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Wm. M. Collins M. D.
Address: 6 E. Eager St. Date signed: 11/1/44

Dr. Collins to 6 E. Eager St.

G22141 G22141

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 194a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital W
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1001 Beaumont Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry W. Short

3 (b) If veteran, name war —

3 (c) Social Security Account No. 109-05-6559

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	married

6 (b) Name of husband or wife Helen Thomas

6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) May 16, 1885

8. AGE: Years	Months	Days	If less than one day
59	5	9	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation ~~Watchmaker~~ Engineer

11. Industry or business Aircraft Manufacturing

FATHER 12. Name Sidney H. Short

13. Birthplace Ohio

MOTHER 14. Maiden Name Mary F. Morrison

15. Birthplace Ohio

16 (a) Informant Mrs. Helen T. Short

(b) Address 1001 Beaumont ave.

17 (a) Cremation (b) Date thereof Oct 2-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location 3601 Frederick ave.

18 (a) Funeral director John O. Mitchell & Sons

(b) Address 1900 Eutaw Place

19 (a) OCT 31 1944 (b) Huntington Williams M.D.
(Date received by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30- 1944, at 9:30 A M

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH

Coronary occlusion

Due to

Other Conditions Bronchitis & hypostatic pneumonia

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Andrews M.D.
Medical Examiner.

Date signed 10-30-44

G22142

460690

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30E

G22142

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution: JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 1d

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 708 N. Loney St. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond Shoulars.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1-30-12

8. AGE: Years	Months	Days	If less than one day
32	9 8	14 28	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation Laborer.

11. Industry or business

FATHER

12. Name Turner Shoulars.

13. Birthplace N.C.

MOTHER

14. Maiden Name Ella Bush

15. Birthplace N.C.

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/1/44 (month) (day) (year)

(c) Cemetery or crematory Asbury's Manor PK

Location Balto County, Md.

18 (a) Funeral director Chas H. Hooper

(b) Address 512 Carollton Ave.

19 (a) OCT 31 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct-28 1944 at 4.10 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept-13 1944, to Oct-28 1944, and that I last saw him alive on Oct-28- 1944.

Immediate cause of death Cardiac failure

Due to Hypertension and syphilitic heart disease

Due to

Other Conditions Pulmonary infarcts Arteriosclerosis fibrillation

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy Syphilitic heart disease

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Albert A. Hutton

Address Johns Hopkins Hosp. Date signed 11-2-44

G22143

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22143 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 910 S. Baylis St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olga Neel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22- 1939

8. AGE: Years 5 | Months - | Days 8 | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name William Neel
13. Birthplace Virginia

MOTHER
14. Maiden Name Dorothy Kidd
15. Birthplace Virginia

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) Removal (b) Date thereof 10/31/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Witthville Va.
Location Virginia

18 (a) Funeral director Wm Cook Inc.
(b) Address 1217 St Paul St.

OCT 31 1944 Huntington Williams MD
(a) (Signature of registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30- 1944, at 6PM M

21. I certify that death occurred on the date above stated; that I attended deceased from 8AM 10-30-1944, to 6PM 10-30-44, and that I last saw h ST alive on Oct. 30, 1944.

Immediate cause of death Heart failure — Duration 2 hours

Due to Shock — Duration 21 hours

Due to Coma — Duration about 12 hrs

Other Conditions Brain tumor

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Brain tumor

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ellis Fier M. D.
Address Baltimore City Hosp. Date signed 10-31-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully written. Be sure correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22144

TO #89534

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 C

Registered No. G22144

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address.....

(c) Hospital or institution:

Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 5 days

(e) Length of stay in Baltimore (yrs., mos., or days) 15 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County.....

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 832 S. Hanover St. (If rural give location)

(e) Citizen of foreign country? No (Yes or No) If yes, name country.....

3 (a) FULL NAME Felix Bennett

3 (b) If veteran, name war.....

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife.....

6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 22, 1925

8. AGE: Years	Months	Days	If less than one day
19	8	9	..... hr. ..... min.

9. Birthplace S. C. (Town, county, and state)

10. Usual Occupation.....

11. Industry or business Maryland Drydock

FATHER: 12. Name Daniel

13. Birthplace S. C.

MOTHER: 14. Maiden Name Bertha White

15. Birthplace S. C.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3-44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location a a Co. Md

18 (a) Funeral director James A Hayes

(b) Address 142 W Fayette St

19 Nov 1 1944 (b) Huntington Williams, M.D.

(Date received by Registrar) (Signature of Registrar)

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1944, at 5:35 AM

21. I certify that death occurred on the date above stated: that I attended deceased from Oct 26th 1944, to Oct 30 1944, and that I last saw h.e alive on Oct 30 1944

Immediate cause of death.....

	Duration
Respiratory failure	
Due to Final Bronchopulmonary Tuberculosis Meningitis	7 days
Other Conditions Pulmonary Tuberculosis	about 4 yrs

(Include pregnancy within 3 months of death)

Date of operation.....

Major findings of operation.....

of autopsy: Pulmonary T.B. Tuberculous Meningitis Final Bronchopulmonary

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide.....

(b) Date of occurrence..... at..... M

(c) Where did injury occur?..... (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature Leo Edmund M.D.

Address Baltimore City Hospitals Date signed 10/31/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22145 ✓ G22145

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined for correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3501 Ellamont Road
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto .
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3501 Ellamont Road (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Bass

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Samuel

6 (c) If alive, give age Years

7. Birth date of deceased (mo., day, yr.) 1886

8. AGE: Years 58 Months — Days If less than one day hr. min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual Occupation
11. Industry or business: House Work

FATHER
12. Name: Hyman Koppelman
13. Birthplace: Russia

MOTHER
14. Maiden Name: Vella Zwalsky
15. Birthplace: Russia

16 (a) Informant: Mr Leon Kappelman
(b) Address: 3501 Ellamont Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 1, 1944 (month) (day) (year)
(c) Cemetery or crematory: Hebrew Friendship Cem
Location: E Baltimore St

18 (a) Funeral director: Sol Levinson & Bros
(b) Address: 1124 1126 W North Ave

19 (a) NOV 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION 44 8.I5

20. DATE OF DEATH Oct. 31 19 at 2 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 19 44 to Oct 31 19 44.
and that I last saw h.e. alive on Oct 31 19 44.

	Duration
Immediate cause of death: Ovarian Cancer	2 mo.
Due to (Carcinoma of Ovary)	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Jaffe M. D.
Address 11 E. Eden St. Date signed 10/31/44

VS 180

G22146

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

92a

Registered No. G22146 (Nov)

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. Lexington st. Parking Lot
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Picard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, ~~widowed, or divorced~~ Married

6 (b) Name of ~~husband or~~ wife Annie Picard

6 (c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years 70 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name (Unknown) Picard

13. Birthplace "

MOTHER 14. Maiden Name "

15. Birthplace "

16 (a) Informant George Deel

(b) Address 2733 Riggs Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/44 (month) (day) (year)

(c) Cemetery ~~or crematory~~ St Marys

Location Hampden

18 (a) Funeral director William Cook Inc

(b) Address 1217 St. Paul St

19 NOV 1 - 1944 Huntington Williams M.D. Registrar
(Date rec'd by Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30, 1944 at 7:15 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Valvular Heart Disease, Aortic Stenosis

Due to Carbon monoxide poisoning

Other Conditions Valvular heart disease Aortic stenosis
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 30/1944 7 P. M.
(b) Where did injury occur? 222 St Paul St.
(c) Did injury occur at home, on farm, industrial place, in public place? Parking Lot While at work?
(d) Means of injury Accidental carbon monoxide poisoning

23. Signature H. Z. Wallenmeyer M.D.
Medical Examiner.
Date signed October 31, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22147

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 73a

G22147 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Provident Hospital
(c) Hospital or institution: U/t Division E. 13ST
(d) Length of stay in hospital or inst. ~~(yrs., mos., or days)~~ 20 days
(e) Length of stay in Baltimore (yrs., mos., ~~or days~~) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town 2523 Madison Ave Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geraua Chew

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	col.	married

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 30, 1890

8. AGE: Years	Months	Days	If less than one day
54	-	-	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Not Known
15. Birthplace " "

MOTHER
14. Maiden Name Not Known
15. Birthplace " "

16 (a) Informant Mr. William H. Chew
(b) Address 2523 Madison Ave.

17 (a) Burial (b) Date thereof 11-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Memorial Park
Location Baltimore Co., Md.

18 (a) Funeral director Mrs Frances A. Hemsley
(b) Address 578 W. Biddle St.

19 (a) (Signature of local registrar) (b) Huntington Williams M.D.

NOV 1 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1944; at 10 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/1944 to 10/30/1944 and that I last saw h[illegible] alive on 10/30/1944

Immediate cause of death: Arteriosclerosis Coronary — Duration: 1 month
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard Higgins M. D.
Address 2243 Madison Ave Date signed 11/3/44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22148 Crane #11

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183

Registered No. G22148

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: 700 East Street 4
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 330 N. Paul Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph N. Williams

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1894

8. AGE: Years 50 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name

13. Birthplace

MOTHER 14. Maiden Name

15. Birthplace

16 (a) Informant

(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)

(c) Cemetery or crematory

Location PUBLIC CEMETERY OCT 31 1944

18 (a) Funeral director Commissioner of Health

(b) Address

NOV 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 25, 1944, at 11:30 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-?-44 at 9:45 A.M. 25/4
(b) Where did injury occur? Foot of Hanover Street
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor. While at work? ?
(d) Means of injury Found drowned in Harbor.

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed October 25, 1944.

G22149
JL - 90375

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95 B

G22149
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 Days
(e) Length of stay in Baltimore (yrs., mos., or days) 13 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 815 Ostend St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME David Poole

3 (b) If veteran, name war	3 (c) Social Security Account No. 228-10-4799

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Jessie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, ? 1906

8. AGE: Years	Months	Days	If less than one day
37 ?	? 11	? 24	hr. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles
13. Birthplace Va.

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof November 2 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Lyon
Location Baltimore County

18 (a) Funeral director Joseph J. Sisly
(b) Address 1600 Mount Street

NOV 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1944, at 12 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1944 to 10-30 1944, and that I last saw him alive on 10-30 1944.

Immediate cause of death Acute bacterial endocarditis.
Meningitis & pneumonia
Due to Pneumococcus Type XII
Due to
Other Conditions Septic infarct of Rt. Cerebral artery & Rheumatic heart disease
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: as above.

Duration
One Mo.
3 days ?

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. M. Phillips M. D.
Address Balt. City Hosp Date signed 10-30-44

G22150

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G22150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. MARGIN RESERVED FOR BINDING
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days) 73 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4027 Fairview Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clinton Ogle. (Clinton James Ogle)

3 (b) If veteran, name war: none

3 (c) Social Security Account No. 216-12-3636

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Hilda Douty Ogle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 25 1871

8. AGE: Years 73 | Months 0 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Director

11. Industry or business Liberty B. & Loan Ass'n.

FATHER
12. Name Jesse Ogle
13. Birthplace Baltimore

MOTHER
14. Maiden Name Willmina Courts
15. Birthplace Baltimore

16 (a) Informant Mrs. Katherine Boone
(b) Address 4027 Fairview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 1 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1944 2:50 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 21 1944 to Oct 30 1944 and that I last saw him alive on Oct 30 1944.

Immediate cause of death Myocardial failure — Duration

Due to Coronary Thrombosis

Due to

Other Conditions Carcinoma of Pyloric Stomach

(Include pregnancy within 3 months of death)

Date of operation 10-21-44

Major findings of operation: Carcinoma (ulcerated) of stomach

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. L. McCormick M. D.
Address Md Gen Hosp Date signed 10-30-44

G22151

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G22151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1306 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1306 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MINERVA A. DOYLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife James E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1853

8. AGE: Years	Months	Days	If less than one day
91			hr. min.

9. Birthplace Milford, Del.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden Name "
15. Birthplace "

16 (a) Informant Mrs. Marie A. Crawford
(b) Address 1608 E. 30th St.

17 (a) Burial (b) Date thereof 11/1/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 - 1944 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30, 1944, at 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 30 1944, and that I last saw her alive on Oct 30 1944.

Immediate cause of death	Duration
Cardiac Asthenia	2 da
Due to Cardiac Decompensation	5 yrs
Hypertension	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. E. Rowe M.D.
Address 806 N Fulton Ave Date signed Oct 31 1944
M. D.

G22152

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93E

Registered No. G22152

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Be correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 3000 Bellona Ave.

(c) Hospital or institution:

Edgewood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1749 Abbottston St.
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME ELIZABETH REESE

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband or wife Louis F. Reese

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/4/1861

8. AGE: Years	Months	Days	If less than one day
83	3	25	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER

12. Name Balthasar Schneider

13. Birthplace Germany

MOTHER

14. Maiden Name Maria E. Seible

15. Birthplace Germany

16 (a) Informant Mrs. Beulah E. Ruebor

(b) Address 1749 Abbottston St.

17 (a) Burial (b) Date thereof 11/1/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) NOV 1 - 1944
(Date received by registrar)

Huntington Millwork, Md.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/29/ 1944 at 7½ M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Oct 29 1944 and that I last saw her alive on Oct 25 1944.

Immediate cause of death	Duration
Hypostatic Pneumonia	4 days
Due to Arteriosclerosis	10 yrs
Due to Cerebral Coronsis	6 yrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature L. D. Zimmerman M.D.

Address 9518 Harford Date signed 10/30/44

22153

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55E ✓ Registered No. 22153

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Lafayette Ave & John. 14
(c) Hospital or institution: Women's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1405 Eutaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth Henley Hurst

3 (b) If veteran, name war —

3 (c) Social Security Account No. — none

4. Sex F.

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Homer

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1871

8. AGE: Years 73 | Months 1 | Days 1 | If less than one day hr. min.

9. Birthplace Virginia (Heathsville) (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Thomas H. Fallin
13. Birthplace Va.

MOTHER
14. Maiden Name Mary J. Crowder
15. Birthplace Va.

16 (a) Informant Mrs. Eliz. D. Claughton
(b) Address 111 - 8th St., Blackstone, Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1944, at 6.13 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 6 1944 to Oct 31 1944, and that I last saw her alive on Oct 31 1944.

Immediate cause of death	Duration
Cardio-respiratory arrest	
Due to Carcinoma, site &	Months
Due to origin undetermined	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation Oct. 14, 1944

Major findings of operation: Metastatic carcinoma

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest E. Bamfield M.D. Address Women's Hosp. Date signed 10/31/44

G22154

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G22154

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Physicians: please write to the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1418 Orleans St.
(c) Hospital or institution: 5

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1418 Orleans St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Richard Chapple

3 (b) If veteran, name war None | 3 (c) Social Security Account No. 218-10-6618

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mattie Chapple

6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) March 15 1906

8. AGE: Years 38 | Months 07 | Days 15 | If less than one day hr. min.

9. Birthplace Dinwiddie County Va (Town, county, and state)

10. Usual Occupation Rigger

11. Industry or business Bethlehem Steel Co.

FATHER
12. Name Alex Chapple
13. Birthplace Va

MOTHER
14. Maiden Name Lydia Roberts
15. Birthplace Va

16 (a) Informant Mattie Chapple
(b) Address 1418 Orleans St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1944 (month) (day) (year)

(c) Cemetery or crematory Arbutus
Location

18 (a) Funeral director Robert L. Conway
(b) Address 502 S. Carrollton Ave.

NOV 1 - 1944 Huntington Williams M.D. (Date rec'd by Registrar) Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1944 at 12.8 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-26 1944 to 10-30 1944 and that I last saw h. alive on 10-30 1944

Immediate cause of death: Hypertensive Cardio-renal disease (uremia) — Duration: 2 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Rayner Browne

Address 1200 E. Madison St Date signed 10/31 M.D.

G22155

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No. G22155

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens & Caton Aves
(c) Hospital or institution:
St Agnes Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 7900 Oakdale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Baby Girl Ratonka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W.	single

6 (b) Name of husband or wife

6 (c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.) 10-29-44

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Baltimore Maryland
(Town, county, and state)
10. Usual Occupation child
11. Industry or business

FATHER
12. Name Frank Ratonka
13. Birthplace Ohio

MOTHER
14. Maiden Name Minnie V. Coughenhour
15. Birthplace Pa.

16 (a) Informant Frank M. Ratonka
(b) Address 7900 Oakdale Avenue

17 (a) Burial (b) Date thereof 11-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Moreland
Location Baltimore

18 (a) Funeral director Leonard J. Lusk
(b) Address 5305 Harford Road

19 (a) NOV 1 - 1944 Huntington Williams, M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1944 to 10-30 1944 and that I last saw her alive on 10-30 1944.

Immediate cause of death Premature

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Howard W Stier M. D.
Address St Agnes Hosp Date signed 11-1-44

MARYLAND RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22156

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G22156

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Edgewood Nursing Hme
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1612 Caroline St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Christina M. Bauer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F. | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13-1871

8. AGE: Years 73 | Months 7 | Days 16 | If less than one day: hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name John Bauer
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Anna B. Hollaneyer
15. Birthplace Germany

16 (a) Informant Miss Margaret Bauer
(b) Address 2708 Garden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. D. Pusk
(b) Address 530 S. Hanford Rd.

NOV 1 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1944, at 11:45 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 7-27-1942 to 10-29-1944, and that I last saw her alive on 10-28-1944.

Immediate cause of death: Carcinoma breast-metas- | Duration: 2½ yrs.
Due to: Tases
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation 7/31/42 and 1/28/44
Major findings of operation: Carcinoma breast - metastases
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo B. Sylvester M. D.
Address 302 Harford Rd Date signed 10-31-44

G22157

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

Registration No. G22157

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2810 Ulman Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2810 Ulman Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fannie Seidel

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Meyer Seidel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1864

8. AGE: Years 80 | Months | Days | If less than one day hr. min.

9. Birthplace Riga (Town, county, and state)

10. Usual Occupation N.W.

11. Industry or business

FATHER: 12. Name David Daniel
13. Birthplace Riga

MOTHER: 14. Maiden Name Sarah
15. Birthplace Riga

16 (a) Informant Family Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-44 (month) (day) (year)
(c) Cemetery or crematory Forest Park
Location Park Circle Hamilton Ellen

18 (a) Funeral director Jack Levin
(b) Address 1437 E. Baltimore St.

19 (a) NOV 1 - 1944 (Date received by registrar) Huntington Williams, M.D. (Signature of registrar)

VE 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31-44 19 , at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1943 to Oct 31 1944.
and that I last saw h alive on Oct 31 1944.

Immediate cause of death	Duration
Acute Cardiac dilation	1 day
Due to	
Due to Arteriosclerosis	2 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature S C Feldman
Address 1440 E Balto St Date signed M 11 D 1 Yr 44

G22158

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 133a

Registered No. G22158

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days) 24 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3114 Fernvale Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sophie [redacted] BARDACH

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife Morris MORTON BARDACH
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1909

8. AGE: Years	Months	Days	If less than one day
35			hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation House Wife
11. Industry or business

FATHER
12. Name Louis Wollach
13. Birthplace Poland

MOTHER
14. Maiden Name Motta
15. Birthplace Poland

16 (a) Informant Morris [redacted] MORTON BARDACH
(b) Address 3114 Fernvale Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-44 (month) (day) (year)
(c) Cemetery or crematory [redacted]dale
Location Old Rd & Hamilton Ave

18 (a) Funeral director Jack Lewis Inc
(b) Address 1439 E. Baltimore St

NOV 1 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

78 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/44 1944 at 9:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/3 1944 to 10/31 1944 and that I last saw her alive on 10/31 1944

Immediate cause of death Cardio-vasc failure — Duration

Due to Septicemia, pyocyaneus organism — Duration

Due to Pyelonephritis — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation Upholstery 10/16/44

Major findings of operation: Pyelonephritis

of autopsy Multiple abscesses of kidney, bladder, ureter & liver

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Leonard Abeman M. D.
Address 5 Wash Sq. Balto. Date signed 10/31/44

(OVER)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G22159

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22159

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 122 X Shields Place
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 51 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 122 X Shields Place
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Wallace Otis Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Augusta Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 7, 1893

8. AGE: Years 51 | Months | Days 22 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name Howard Johnson
13. Birthplace Md

MOTHER
14. Maiden Name Sarah Gray
15. Birthplace Md.

16 (a) Informant Augusta Johnson
(b) Address 114 Myrtle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-1-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St.

19 (a) NOV 1 1944 (Date received by Registrar) (b) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 29 19XX at 4:30 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22 19XX to Oct 29 19XX, and that I last saw alive on Oct 29 19XX

Immediate cause of death	Duration
Cerebral Hemorrhage	7 days
Due to Hypertension	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature E. William Frey
Address 1928 Pa Ave Date signed 10/31/44 (M.D.)

G22160 ✓ G22160

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 195E

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 879 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME (Bennie) Bernard (Buckley) Purcha

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife Eliza

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 15 1912

8. AGE: Years	Months	Days	If less than one day
32	9	14	hr. min.

9. Birthplace Sumter - S.C. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Buash Purcha

13. Birthplace Webb Manor — S.C.

MOTHER 14. Maiden Name Chaney Taylor

15. Birthplace Sumter - S.C.

16 (a) Informant Mrs. Chaney Purcha

(b) Address 879 W. Fairmount Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-44 (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn

Location Mt. Winans

18 (a) Funeral director Mrs Katie R. Williams

(b) Address 322 N. Schroeder St.

(c) NOV 1 - 1944 (Date received by Registrar) Huntington Williams Mgr.

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1944, at 2 40 A M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH History of Fracture of Neck

Softening of Spinal Cord.

Due to Pulmonary Embolism due to thrombosis of left iliac vein

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury July 6 1944 M.

(b) Where did injury occur? Chas. & Tompkins, Wash. D.C.

(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes

(d) Means of injury Lifting bag of cement material

23. Signature Robert Lee Foster M.D. Medical Examiner.

Date signed 10-30-44

(Over)

VS 151

G22161

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 163

Registered No. G22161

Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4501 St Thomas Ave.
(If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Howard C. Ruark

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	( )

6 (b) Name of husband or wife Thedis Jones
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 10-13-1895

8. AGE: Years	Months	Days	If less than one day
49 Yr		13	..... hr. ..... min.

9. Birthplace Bishops Head (Dorchester Co.)
(Town, county, and state)
10. Usual Occupation Glenn L. Martin
11. Industry or business Aircraft

FATHER
12. Name Howard R. Ruark.
13. Birthplace Md

MOTHER
14. Maiden Name Annie Johnson
15. Birthplace Md.

16 (a) Informant Mrs Thedis Ruark.
(b) Address Balto. Md.

17 (a) Cambridge Md. (Burial, cremation, or removal) Date thereof 11/3/44. (month) (day) (year)
(c) Cemetery or crematory.....
Location Cambridge, Md.

18 (a) Funeral director Le Compte Funeral Home
(b) Address Cambridge, Md.

19 NOV 1 - 1944 (Date filed by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1944, at 6:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Asphyxiation
due to Carbon Monoxide

Due to.....

Other Conditions Mental Despondency

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 31 1944 at 5:30 P.M.
(b) Where did injury occur? 4501 St. Thomas Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Inhaled gas from kitchen stove

23. Signature Robert Le Grate M.D.
Medical Examiner.
Date signed Nov. 1 1944

G22162

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170C

Registered No. G22162

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 months
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5246 St. Charles Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William O. Stinchcomb

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Eliza Ella Stinchcomb

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) July 20-1871

8. AGE: Years	Months	Days	If less than one day
73	3	9	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Packer

11. Industry or business Ward Baking Co.

FATHER 12. Name William Stinchcomb

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden Name Margaret Benson

MOTHER 15. Birthplace Maryland

16 (a) Informant Mrs. Emma Babylon

(b) Address 3908 Dolfield Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2-1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Marys Hampden

Location Baltimore, Maryland

18 (a) Funeral director Burger Funeral Home

(b) Address 3631 Falls Road

NOV 1 - 1944 (Date rec'd by registrar) (c) Huntington Williams M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1944, at 10 45 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fractured Skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 16/5

(a) Date of injury 10-29- at 10.05 P M.

(b) Where did injury occur? Edmondson Ave. near Bentalou

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Pedestrian, struck by automobile

23. Signature Howard J. Wellein M.D.
Medical Examiner.

Date signed 10-30-44

VS 151

G22163

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G22163 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 604 N. Carrollton Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) Lifetime
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County —
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 N. Carrollton ave
(If rural, give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country —

3 (a) FULL NAME Wells Locks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4 Sex: Male | 5. Color or race: Col. | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1877

8. AGE: Years 67 | Months 3 | Days 20 | If less than one day — hr. — min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Laborer

11. Industry or business —

FATHER 12. Name John Locks.
13. Birthplace Maryland

MOTHER 14. Maiden Name Ada Barnett
15. Birthplace Maryland

16 (a) Informant Lillie Hobbs daughter
(b) Address 604 N. Carrollton Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3-1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Brooklyn

18 (a) Funeral director Wm Brooks
(b) Address 1463 N. Carey St

NOV 1 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1944, 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1944 to 10-30 1944 and that I last saw h alive on 10-30 1944.

Immediate cause of death: Lobar Pneumonia — Duration 3 days

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —

23. Signature C. J. Pifer, M.D.
Address 1536 W Lanvale St Date signed 11-31-44

For Timbol - 1703 Edmondson Ave

G22164

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22164 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2544 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2544 Edmondson Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Charles Philip Hoffman

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widowed

6 (b) Name of husband or wife Living, Mrs. Born
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 26th 1864

8. AGE: Years	Months	Days	If less than one day
80	8	5	hr. min.

9. Birthplace Philadelphia, Pa.
(Town, county and state)
10. Usual Occupation Glass Blower
11. Industry or business Retired

FATHER
12. Name Jacob Hoffman
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Eckardt
15. Birthplace Germany

16 (a) Informant Mrs. Lauretta Forrest
(b) Address 2544 Edmondson Ave

17 (a) Buried (b) Date thereof 11 (month) 2 (day) 44 (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Geo. Waban & Son
(b) Address 2503 Edmondson Ave

19 NOV 1 1944 Huntington Williamsport
(Date) (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31st 1944, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-17-44 19__, to 10-31 1944.
and that I last saw him alive on 10-31-1944.

Immediate cause of death Coronary Thrombosis — Duration 7

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry B. Gundel M. D.
Address 2703 Edmondson Ave Date signed 11-1-44

G22165 To Be Approved by Medical Examiner ✓ G22165

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47c

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Space correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 901 W Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) City Baltimore
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 901 W Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Susie Cooper.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife Joseph Cooper.
(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 25, 1875

8. AGE: Years	Months	Days	If less than one day
68	10	3	hr. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Perry Mc Pherson
13. Birthplace ? ?

MOTHER
14. Maiden Name Margaret ?
15. Birthplace St Marys Co Md

16 (a) Informant Mrs Liviana Davis.
(b) Address 901 W Saratoga St

17 (a) Buried (b) Date thereof 11/1/1944.
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt Century Cemetery
Location West Port Md.

18 (a) Funeral director Mrs Katie R Williams
(b) Address 322 N Schroeder St.

NOV 1 1944 (b) Huntington Williams M.D.
(Date received by Registrar) for C.R.L. Graham, by Howard J. Clemens M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 28th 1944 at 8.25 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19..., to 19..., and that I last saw h... alive on 19...

Immediate cause of death	Duration
Bronchogenic Carcinoma	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Clemens M.D.
Address 624 Arlington Ave Date signed 10-1-44

G22166

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 30c

G22166
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline ST.
(c) Hospital or institution: St. Josephs Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1420 E. Monument ST
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Dexter

3 (b) If veteran, name war —
3 (c) Social Security Account No. [redacted]

4. Sex M | 5. Color or race C | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Katherine Dexter
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Balto, Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name George N. Dexter
13. Birthplace Md.

MOTHER 14. Maiden Name Catherine Collins
15. Birthplace Md

16 (a) Informant George N. Dexter Jr
(b) Address 32 N. Washington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 1st 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location A. A. Co. Md

18 (a) Funeral director Belmont & Jamie H. Wright
(b) Address 700 Aliceanna St

19 (a) (Date rec'd by registrar) (b) Huntington Wm. Registrar

NOV 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-27- 1944, at 9:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-21 1944, to 10-27 1944, and that I last saw h[illegible] alive on 10-27 1944.

Immediate cause of death	Duration
Pulmonary Embolism	
Due to arteriosclerosis	
Due to	
Other Conditions Central Nervous system syphilis, lung abscess	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy: Yes

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M E Robertson M. D.
Address St. Josephs Hospital Date signed 10-28-44

G22167

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48 B

G22167 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5368 Liberty Heights Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5368 Liberty Heights Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Dorothy Margaret Hollenshade

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Robt. W. Hollenshade
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Aug 17 1902

8. AGE: Years	Months	Days	If less than one day
42	2	14	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)
10. Usual Occupation Telephone operator
11. Industry or business Cambridge Arms Apts

FATHER
12. Name Patrick A. Jackson
13. Birthplace Ireland

MOTHER
14. Maiden Name Maria Ward
15. Birthplace Ireland

16 (a) Informant Robert W. Hollenshade
(b) Address 5368 Liberty Heights Ave

17 (a) Burial (b) Date thereof Nov 3 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Harry A. Amacost
Address 2204 Ridgewood Ave

19 (a) NOV 1 1944 Lillington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944, at 6:30 P M

21. I certify that death occurred on the date above stated that I attended deceased from Sept 1944 to Oct 31 1944 and that I last saw h[illegible] alive on Oct 31 1944.

Immediate cause of death	Duration
Uraemia	
Due to Carcinomatosis	
Due to Carcinoma of uterus	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L. Polonick M.D.
Address 4710 Liberty Hts. Date signed 11/1/44

VS 150

G22168

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1634

Registered No. G22168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 922 S. Decker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 S. Decker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Dell

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. Dell

6 (c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): Mar 25, 1907

8. AGE: Years	Months	Days	If less than one day
37	7	5	hr. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: Frederick Berends
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden Name: Louisa Meyers
15. Birthplace: Baltimore, Maryland

16 (a) Informant: William Dell
(b) Address: 922 S. Decker Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-44 (month) (day) (year)
(c) Cemetery or crematory: Mt. Carmel Cemetery
Location: Baltimore, Maryland

18 (a) Funeral director: Henry Sander & Sons, Inc.
(b) Address: North Ave. & Broadway

19 NOV 1 - 1944 (Date rec'd by Registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1944 at 12:25 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carbon monoxide poisoning

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-30-44 11 A M.
(b) Where did injury occur? 922 S. Decker Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No
(d) Means of injury (gas) Carbon Monoxide Asphyxiation.

23. Signature [illegible] M.D. Medical Examiner.
Date signed October 30, 1944.

VS 151

G22169

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

~~G22169~~ 168 Registered No.

1. PLACE OF DEATH: 922 S. Decker Ave
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 922 S. Decker Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THOMAS WILLIAM DELL

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 24, 1929

8. AGE: Years 15 | Months 4 | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER
12. Name William Dell
13. Birthplace Baltimore, Maryland

MOTHER
14. Maiden Name Catherine perends
15. Birthplace Baltimore, Maryland

16 (a) Informant William Dell
(b) Address 922 S. Decker Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Avenue & proadway

19 (a) (b) Huntington Williams, M.D. Registrar
NOV 1 1944 (Date received by registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 30 1944, at 12:26 P. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carbon monoxide poisoning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-30-44 at 11 P.M.
(b) Where did injury occur? 922 S. Decker Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? Home While at work? No
(d) Means of injury Carbon Monoxide Asphyxiation

23. Signature H. Williams M.D. Medical Examiner.
Date signed October 30, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22170

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G22170

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 136 S. Curley Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 136 S. Curley St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ELLA CECELIA MILLER

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. F. Miller

6 (c) If alive, give age: 56 years

7. Birth date of deceased (mo., day, yr.): Sept. 9, 1888

8. AGE: Years 56 | Months 1 | Days 20 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md
(Town, county, and state)

10. Usual Occupation: At Home

11. Industry or business

FATHER
12. Name: John Gordon Finnerty
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Margaret Conners
15. Birthplace: Ireland

16 (a) Informant: Mr. Wm. F. Miller
(b) Address: 136 S. Curley Street

17 (a) Burial (b) Date thereof 11-2-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory: Most Holy Redeemer
Location: Baltimore, Md

18 (a) Funeral director: Henry Sander & Sons, Inc
(b) Address: North Ave. & Broadway

19 NOV 1 - 1944 (b) Huntington Williams, M.D. Registrar
(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 29, 1944 19 , at 11 AM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1944, to Oct 29 1944, and that I last saw h GR alive on Oct 29 1944.

Immediate cause of death	Duration
ARTERIOSCLEROSIS.	5 MO
Due to CARDIO VASCULAR RENAL DISEASE	5 MO
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature: Jerry F Kavanagh M.D.
Address: 3305 Fd Edwyld Date signed: Nov 31-44 M. D.

VS 150

G22171

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46a

Registered No. G22171

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 W Fayette St
(c) Hospital or institution: Bon Secours Hosp 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 40 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balt. City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2426 Green Mount Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vernon Milton Stehling

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	212-09-3835

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Divorced

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/15/97

8. AGE: Years	Months	Days	If less than one day
46	11	16	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Baker
11. Industry or business Bakery

FATHER
12. Name Wm. I. Stehling
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Warnken
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. Clara Schmalbach
(b) Address 2710 Southern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-2-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk. Cem
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address Worth Ave. & Broadway

NOV 1 1944 (b) Huntington Williams, M.D. Registrar
Date received by Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/31/44 19 , at 9 45 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22/44 19 , to 10/31/44 19 , and that I last saw him alive on 10/31/44 19 .

Immediate cause of death	Duration
Liver Abcess	
Due to Carcinoma of the Esophagus + Cardiac Por.	
Due to tion of the Stomach involving the liver	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Francis L. Grumbine M. D.
Address Date signed 10/31/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22172

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

469

G22172 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Ensor St~~
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
Baltimore, Md
(c) City or town 1823 Ensor St
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK LAZZARO

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 218-10-1084

4. Sex: Male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bertha Lazzaro

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) Dec 26, 1889

8. AGE: Years 54 | Months 53 | Days 10 | If less than one day: hr. 5 min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business Bethlehem Steel/Shipyard

FATHER
12. Name Lazzaro, Joseph (Deceased)
13. Birthplace Italy

MOTHER
14. Maiden Name Amador, Made, Irene
15. Birthplace Italy

16 (a) Informant Bertha Lazzaro
(b) Address 1823 Ensor St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dippel's Sons
(b) 22nd & Ann St.

19 (a) NOV 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944 at 3:30 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1944, to 10-31 1944 and that I last saw h[illegible] alive on 10-31 1944

Immediate cause of death: Carcinoma of tail of pancreas

Due to: Metastasis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy: Carcinoma

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert D Doty

Address Broadway & Fairmount Ave. Date signed 11/2/44

G22173

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1210

G22173 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1210 Hill St
(c) Hospital or institution: V4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1210 Hill (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Pauline Gralewski (GRALEWSKI)

3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Leon Gralewski
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 10 1879

8. AGE: Years	Months	Days	If less than one day
64	11	20	hr. min.

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Adam Nekiel
13. Birthplace Poland

MOTHER
14. Maiden Name Frances Pawlicki
15. Birthplace Poland

16 (a) Informant Mrs Mary Wiszniewski
(b) Address 1710 Hill St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary Cem
Location Baltimore County

18 (a) Funeral director John M. Weber
(b) Address 40[illegible] S. Chester Street

NOV 1 1944 (Date received) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 30 1944, at 5.15 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1944, to Oct 30 1944 and that I last saw h.er alive on Oct 30 1944

Immediate cause of death	Duration
Uraemia Coma	5 d.
Bronch Pneumonia	3 d
Due to arterio Sclerosis	6 y.
Hypertension	6 y.
Due to Chr Interstitial Nephritis	0 to y
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature T F A Stevens M. D.
Address 2818 Harford Rd Date signed 11-1-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. If correction is especially important.

G22174

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G22174
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 N. Patterson Park Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 N. Patterson Park Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ROBERT H. KREISEL

3 (b) If veteran, name war	3 (c) Social Security Account No.
None	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Lillian M. Kreisel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1889

8. AGE: Years	Months	Days	If less than one day
55	8	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Special police
11. Industry or business Sugar Refinery

FATHER
12. Name Otto Kreisel
13. Birthplace Germany

MOTHER
14. Maiden Name Louise Wack
15. Birthplace Germany

16 (a) Informant Mrs. Lillian M. Kreisel
(b) Address 1721 N. Patterson Park Ave.

17 (a) Burial (b) Date thereof 11/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location Baltimore, Md.

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2008 Orleans St.,

19 NOV 1 - 1944 Huntington Williams
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30-44 1944, at 4 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28- 1944, to 10-30- 1944, and that I last saw him alive on 10-30- 1944

Immediate cause of death	Duration
Coronary Thrombosis	39 hours
Due to Arteriosclerosis	2
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Milton C. Lang M. D.
Address 2117 Belay Rd Date signed 10-31-44

G22175

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22175

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; the correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fountain & Linn
(c) Hospital or institution: University
(d) Length of stay in hospital or inst. (~~yrs., mos., or~~ days) 1 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 445 S. 25th St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace S. Kline

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife unknown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 04 5, 1890

8. AGE: Years 54 | Months 0 | Days 26 | If less than one day hr. min.

9. Birthplace Lancaster, Pa
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name George Weidler
13. Birthplace Penna.

MOTHER
14. Maiden Name Unknown
15. Birthplace Penna.

16 (a) Informant
(b) Address

17 (a) Removal (b) Date thereof 11-1-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location " "

18 (a) Funeral director W. W. Chambers Co.
(b) Address Washington, D.C.

19 (a) NOV 1 - 1944 (b) Harrington Williamson, M.D.
(Date rec'd by registrar) for O.R. Lobaugh, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 1944 at 1:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1944 to 11-1 1944, and that I last saw h[illegible] alive on 11-1 1944.

Immediate cause of death Spontaneous Subarachnoid Hemorrhage — Duration

Due to Hypertension 2 yrs.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Frank M. Slaughter M. D.
Address University Hosp. Date signed 11-2-44
for Howard J. Mercer, M.D.

G22176

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1578

Registered No. G22176

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution:
The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2days
(e) Length of stay in Baltimore (yrs., mos., or days) 2days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County.....
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3445 Kenyon Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3 (a) FULL NAME Baby McClaskyy

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 18,1944

8. AGE: Years	Months	Days	If less than one day
		2	..... hr. ..... min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation.....
11. Industry or business

FATHER
12. Name William D. McClaskey
13. Birthplace Maryland

MOTHER
14. Maiden Name Evelyn Orndorff
15. Birthplace Pennsylvania

16 (a) Informant Hospital records
(b) Address Johns Hopkins Hospital

17 (a)..... (Burial, cremation, or removal) (b) Date thereof..... (month) (day) (year)
(c) Cemetery or crematory.....
Location JOHN HOPKINS MEDICAL SCHOOL NOV 1 1944
18 (a) Funeral director Commissioner of Health
(b) Address.....
19 NOV 1 - 1944 (Date rec'd by registrar) Hamilton Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20 1944, at 1.20 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 18 1944, to Sept. 20 1944, and that I last saw him alive on Sept. 20 1944.

Immediate cause of death	Duration
Congenital heart disease: Patent ductus arteriosus	
Due to.....	
Due to.....	
Other Conditions..... (Include pregnancy within 3 months of death)	

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature M. S. Griffith, M.D. M. D.
Address Johns Hopkins Hospital Date signed 9-23-44

VS 150

2273

G22177

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22177
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 E. Biddle Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Knight

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1944

8. AGE: Years	Months	Days	If less than one day
			12 hr. 13 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business

FATHER
12. Name Willie Knight
13. Birthplace North Carolina

MOTHER
14. Maiden Name Lucille Armstrong
15. Birthplace North Carolina

16 (a) Informant Hospital Records
(b) Address Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location [illegible] MEDICAL SCHOOL NOV 1 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 1 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 12 1944, at 11:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 11 1944, to Oct. 12 1944, and that I last saw him alive on Oct. 12 1944.

Immediate cause of death	Prematurity	Duration
Due to		
Due to		
Other Conditions		

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith, M.D.
Address Johns Hopkins Hospi Date signed 10-19-44

2272

G22178

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22178 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3116 Berkshire Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3116 Berkshire Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) FULL NAME William J. Deppenbrock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M.	W.	Widowed

6 (b) Name of husband or wife. Carrie S. Hedekind
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 4, 1874

8. AGE: Years	Months	Days	If less than one day
70	9	27	hr. min.

9. Birthplace St. Louis, Mo.
(Town, county, and state)
10. Usual Occupation Draftsman Designer
11. Industry or business

FATHER
12. Name Hy. T. Deppenbrock
13. Birthplace Germany

MOTHER
14. Maiden Name Maria
15. Birthplace Germany

16 (a) Informant Mina Audrey R. Deppenbrock
(b) Address 3116 Berkshire Rd.

17 (a) Burial (b) Date thereof 11/3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director F. B. Shipperd & Son
(b) Address 1300 Eutaw Place

19 NOV 1 - 1944 Huntington Williams M.D.
(Date received by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1944, at 7:20 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE (OF DEATH Arteriosclerotic
Cardio Vascular disease

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 1 1944

G22179 G22179

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1945 B

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Green & Redwood Sts.
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1½ days
(e) Length of stay in Baltimore (yrs., mos., or days) 1½ days

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (County) Howard
(c) City or town Glenwood
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME LOUISE M. GAITHER

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 19, 1896

8. AGE: Years 48 | Months 2 | Days 12 | If less than one day: hr. min.

9. Birthplace Glenwood Howard Co. Md.
(Town, county, and state)

10. Usual Occupation Trained Nurse
11. Industry or business Retired

FATHER
12. Name Daniel H. Gaither
13. Birthplace Glenwood, Md

MOTHER
14. Maiden Name Edith Mobley Gaither
15. Birthplace Brookville, Montgomery Co. Md.

16 (a) Informant Mrs. Edith M. Gaither
(b) Address Glenwood, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2, 1944 (month) (day) (year)
(c) Cemetery or crematory Oak Hope
Location Glenwood, Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City Md.

NOV 1 - 1944 (Date rec'd by registrar)
(b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1944, at 3:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 29 1944, to Oct. 31 1944, and that I last saw her alive on October 29 1944

Immediate cause of death Cardiac failure — Duration 1½ days

Due to Chronic rheumatic heart disease

Due to

Other Conditions cerebral embolism

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

If autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Charles D. Chaffee
Address Greene & Lombard Sts. Date signed M. 11/3 D. 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully given. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 G22180

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22180

Registered No. 83a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1537 N. Stricker St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 58 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1537 Stricker St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bessie Walker Watson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 29 1886

8. AGE: Years 58 | Months 7 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Turner Lilla
13. Birthplace Va

MOTHER
14. Maiden Name unknown
15. Birthplace

16 (a) Informant Neil Parham
(b) Address 516 N. Eden St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott Jr.
(b) Address 1129 N. Caroline St.

19 (a) Huntington Williams M.D.
(Date rec'd by registrar) Registrar

NOV 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944 at 3:15 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 22 1944 to Oct 31 1944 and that I last saw h[illegible] alive on Oct 31 1944

Immediate cause of death: Cerebral Hemorrhage — Duration 9 hrs

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 11/1/44

G22181

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22181
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 10
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 913 Central Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Young

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 7, 1910

8. AGE: Years	Months	Days	If less than one day
33 34	10	24	hr. min.

9. Birthplace Henderson N. Carolina
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name James Lehigh
13. Birthplace N. C

MOTHER
14. Maiden Name Julia Young
15. Birthplace N.C

16 (a) Informant James Young
(b) Address 913 N. Central Ave

17 (a) Burial (b) Date thereof Nov. 3/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A.A. County Md.

18 (a) Funeral director Mrs. Robert A. Elliott
(b) Address 1129 N. Caroline St.

19 (a) 1944 Huntington Williams M.D.
(Date received by Registrar) Registrar

NOV 1

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1944, at 9:55 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Diabetes Mellitus.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D.
Medical Examiner.
Date signed October 31, 1944.

G22182

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G22182 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2450 Brentwood Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 7 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2450 Brentwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Thornton Sr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Divorced

6 (b) Name of husband or wife Virginia

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1885

8. AGE: Years	Months	Days	If less than one day
59	5	19	hr. min.

9. Birthplace Virginia (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER 12. Name Frank Thornton

13. Birthplace Va.

MOTHER 14. Maiden Name Catherine Burrell

15. Birthplace Va.

16 (a) Informant John Thornton Jr.

(b) Address 2450 Brentwood Ave

17 (a) Removal (b) Date thereof Nov 3/44 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory

Location Gloucester Co. Virginia

18 (a) Funeral director Mrs. Robert A. Blanton

(b) Address 1129 N. Caroline St.

19 (a) (b) (Date rec'd by registrar) Williams, Registrar

NOV 1 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1-44 19 , at 4:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1, 1944, to Nov 1, 1944, and that I last saw him alive on Oct 30, 1944.

Immediate cause of death	Duration
Hypertension Cardio Renal Dem	1 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Maurice Thorn M. D.

Address 312 E 23rd St Date signed 11-1-44

MARGIN RESERVED FOR RECORDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22183

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

740

Registered No. G22183

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square 20-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 12 N Fourth St
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country —

3 (a) FULL NAME John Wall

3 (b) If veteran, name war: None
3 (c) Social Security Account No. 213-05-3121

4. Sex: M
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Benitta Wall
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 19-1914

8. AGE: Years 30 | Months 6 | Days 18 | If less than one day: hr. 2 min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation Bricklayer Worker

11. Industry or business Pittsburg Plate Glass Co

FATHER
12. Name John Wall
13. Birthplace Md.

MOTHER
14. Maiden Name Minnie Fuller
15. Birthplace Md.

16 (a) Informant Mrs. Benitta Wall
(b) Address 12 N. Fourth Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director George L. Schmick
(b) Address 201 Frederick Avenue

19 (a) NOV 2 - 1944 (Date rec'd by registrar) Registrar

VS 15

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1-44 19 at a M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1944 to 11-1 1944 and that I last saw him alive on 10-31 19 44

Immediate cause of death: acute lymphatic leukemia — Duration 1 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm B Schreiber M. D.
Address 57 S. Fulton Ave Date signed 11-1-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

C622184

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

462

Registered No. C622184

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden Ave
(c) Hospital or institution:
Maryland General Hospital 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 370 Forrest St (Actual residence)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Vincent Brocato

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: late Carmela

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 10 1872

8. AGE: Years 72 | Months 10 | Days 19 | If less than one day: hr. min.

9. Birthplace Cefalu Italy
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Simore Brocato
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Brocato
15. Birthplace Italy

16 (a) Informant Rose Brocato
(b) Address 2936 Westwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2nd/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt. Md.

18 (a) Funeral director Frank Della Rose
(b) Address 132 N. Morley St.

NOV 3 - 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 29 1944 at 6.00 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/v 1944 to 10/29 1944 and that I last saw him alive on 10/29 1944.

Immediate cause of death Bilateral pneumonia — Duration 2 days

Due to Post-operative to abdominal-perineal resection — 9 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10/20/44

Major findings of operation: Carcinoma of rectum

of autopsy: Bilateral Pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. H. Traynor M. D.
Address Md. Gen'l Hosp. Date signed 10/31/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.
correct age is especially important.

MARGIN RESERVED FOR BINDING

22185

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22185

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 603 Gold St
(c) Hospital or institution: 15
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 603 Gold St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clara E. Gray

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colrd	married

6 (b) Name of husband or wife Wm Gray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1887

8. AGE: Years	Months	Days	If less than one day
57	1	26	hr. min.

9. Birthplace Balto. (Town, county, and state)
10. Usual Occupation at Home
11. Industry or business

FATHER
12. Name Benj Boyer
13. Birthplace md

MOTHER
14. Maiden Name Sarah Banks
15. Birthplace Md

16 (a) Informant Wm Gray
(b) Address 603 Gold St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director James A Taylor
(b) Address 142 W Fayette St.

NOV 2 - 1944 Huntington Williams, M.D.
(Date rec'd by Registrar) Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1944 at 10 30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 9-28 1944 to 11-1 1944, and that I last saw h alive on 11-1 1944.

Immediate cause of death — Duration

Coronary Thrombosis 9 d.

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas H Thacker M. D.
Address 961 Hanlon Date signed 11-2-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians; please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR RECORDING

G22186

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22186 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 334 Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 41
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Chapel Gate Lane (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Ora G Turner

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Widow

6 (b) Name of husband or wife John A Turner
6 (c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Feb 19, 1882

8. AGE: Years	Months	Days	If less than one day
62	8	12	____ hr. ____ min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business —

MOTHER FATHER
12. Name Samuel C. Garthright
13. Birthplace Va
14. Maiden Name Sallie J Heath
15. Birthplace Va

16 (a) Informant Mrs. J. P. Dickinson
(b) Address 605 Chapelgate Ln.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 5 1944 (month) (day) (year)
(c) Cemetery or crematory Richmond
Location Richmond, Va.

18 (a) Funeral director Frederick H. Cole
(b) Address 1200 N. Loudon St.

19 NOV 2 - 1944 (Date received by Registrar) (b) Baltimore, Md.

VS 186

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 1944 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9-22 1944 to 11-1 1944, and that I last saw her alive on 11-1 1944

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Coronary Thrombosis	1 Hrs ?
Due to Hypertensive Cardio-Vascular Disease.	15 yrs ?
Other Conditions Diabetes Mellitus.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. Lee Thompson Jr. M. D.
Address 732 E. University Pkwy Date signed 11/3/44

G22187

HEALTH DEPARTMENT—CITY OF BALTIMORE

G22187

CERTIFICATE OF DEATH.

1310

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 E. Hoffman ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Buckler St Thomas

(a) RESIDENCE No. 1204 E. Hoffman ST., ... WARD 9-9

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Lewis Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Sarah Starr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant James Drury

(Address) 2814 Barrenswood ave

NOV. 2 - 1944 Huntington Williams M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10/31 1944

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1944, to Oct 31, 1944, that I last saw h[illegible] alive on 10/31, 1944 and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio-Vascular Renal Disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Joseph S. Bloom M. D.

, 19 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	11/4 1944
20 UNDERTAKER	ADDRESS
Henry Lutz	1203 N. Broadway

G22188

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22188 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians; please write the

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1261 Sargeant St.
(c) Hospital or institution: 21-
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1261 Sargeant St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank E. Smith

3 (b) If veteran, name war: no.
3 (c) Social Security Account No. 213-09-6650

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lillian F. Smith
6 (c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Dec. 7, 1892

8. AGE: Years 51 | Months 10 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation Drop Worker.

11. Industry or business Mc. Kenzie Co.

FATHER 12. Name Joseph E. Smith
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Mary A. Dehn
15. Birthplace Balto. Md.

16 (a) Informant Lillian F. Smith
(b) Address 1261 Sargeant St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3, 1944 (month) (day) (year)
(c) Cemetery or crematory Western
Location City

18 (a) Funeral director Wm. Mud, John H. Teufel & Son
(b) Address 801 W. Lafayette St.

19 Nov 2, 1944 (b) Filed by Huntington Williams, M.D.

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944, at 7A M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/30 19 44 to 10-31 19 44 and that I last saw h[illegible] alive on 10/31 19 44

Immediate cause of death: Coronary Thrombosis
Duration: Instant

Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature Dr. Tucker F. Lowthorpe M. D.
Address 1765 S. Eaton Date signed 10/5/44

G22189 BALTIMORE CITY HEALTH DEPARTMENT G22189
CERTIFICATE OF DEATH 107 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Date of birth must be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2626 Boone St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Boone St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME James E. Brown
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M. 5. Color or race Col 6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 6/18/1944
8. AGE: Years Months 4 Days 13 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation None
11. Industry or business
FATHER 12. Name Calvin Brown
13. Birthplace Md
MOTHER 14. Maiden Name Bessie McNorton
15. Birthplace Va
16 (a) Informant Bessie Brown
(b) Address 2626 Boone St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 2 44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location B. A. Co
18 (a) Funeral director Palmer Sanders
(b) Address 1413 E. Preston St
NOV 2 1944 (b) (Registrar) Huntington Hollins, M.D. Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH 10-31-44 19 , at M
21. I certify that death occurred on the date above stated; that I attended deceased from 10-26-44 19 to 10-31- 1944 and that I last saw h alive on 10-31-44 19
Immediate cause of death Bronchopneumonia
Duration 5 da
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Maurice Adams M. D.
Address 312 E 23rd Date signed 11-1-44

VS 150

G22190 BALTIMORE CITY HEALTH DEPARTMENT G22190

CERTIFICATE OF DEATH 157 M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days).....
(e) Length of stay in Baltimore (yrs., mos., or days).....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 628 N. Eden St (If rural give location)
(e) Citizen of foreign country?..... (Yes or No) If yes, name country.....

3 (a) FULL NAME Theodore Colson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife.....
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 7-11-44

8. AGE: Years	Months	Days	If less than one day
	3	20	..... hr. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual Occupation.....
11. Industry or business.....

FATHER
12. Name Theodore Colson
13. Birthplace N Ca

MOTHER
14. Maiden Name Theresa
15. Birthplace Balto

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-2-44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Q Q Co

18 (a) Funeral director Rayner Sanders
(b) 1604 Preston St

NOV 2 1944

19 (a)..... (Date rec'd by registrar) (b)..... Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1944 at 7:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from July 11 1944 to Nov 1 1944 and that I last saw h.. alive on Nov 1 1944

Immediate cause of death	Duration
Pleuritis Obstruction	
Due to mucous	
Due to pt tracheotomized	
Other Conditions for Croup laryngeal obstruction	

(Include pregnancy within 3 months of death)

Date of operation.....
Major findings of operation:.....
of autopsy:.....

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide.....
(b) Date of occurrence..... at ..... M
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place?..... While at work?..... (Specify type of place)
(e) Means of injury.....
23. Signature Robert Kaye
Address Jo Hosp (Date signed) 11/3/44

Huntington Williams, M.D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22191 ✓ G22191

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 N. Hilton St.
(c) Hospital or institution: 16-8
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 26 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry H. Hild ✓

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-4723

4. Sex M. | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 28, 1913

8. AGE: Years 31 | Months 3 | Days 23 | If less than one day hr. min.

9. Birthplace Clenton, Md (Town, county, and state)

10. Usual Occupation Ship Fitter

11. Industry or business Beth. Fairfield

FATHER 12. Name James L. Held

13. Birthplace Pa

MOTHER 14. Maiden Name Ruth M. Vogler

15. Birthplace U. S.

16 (a) Informant Mrs. Ruth M. Hild

(b) Address 708 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3/44 (month) (day) (year)

(c) Cemetery or crematory Westerly

Location Monument & Longwood Sts

18 (a) Funeral director Harry H. Duffie

(b) Address 4101 E Monument Ave

NOV 2 – 1944 (b) (Date rec'd by local reg.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31/44 19 , at 5-30 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1944, to Oct 31 1944, and that I last saw h— alive on Oct 31 1944

Immediate cause of death Lobar Pneumonia — Duration 3 days

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. A. Lally M. D.

Address 751 E Edmondson Date signed Nov 4 '44

Huntington Williams M.H

Bur 2.556

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22192 ✓ Registered No. G22192

G22192 169

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address.....
(c) Hospital or institution: Baltimore City Hospitals 20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) 37 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County.....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 407 Gwynn Avenue (If rural give location)
(e) Citizen of foreign country?.....(Yes or No)
If yes, name country.....

3 (a) FULL NAME Andrew C. Roseberry
3 (b) If veteran, name war
3 (c) Social Security Account No. 216-12-3607

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Elizabeth Jane
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) May 23, 1891
8. AGE: Years 53 | Months 5 | Days 8 | If less than one day ....hr. ....min.
9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Conductor
11. Industry or business Penna. R.R.

FATHER
12. Name John C. Roseberry
13. Birthplace Tenn.

MOTHER
14. Maiden Name Cornelia King
15. Birthplace Virginia

16 (a) Informant Mrs. Elizabeth Roseberry
(b) Address 407 Gwynn Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.3.44 (month) (day) (year)
(c) Cemetery or crematory Western
Location Balto. Md.

18 (a) Funeral director Harry N. Wittle
(b) Address 4101 Edmondson Ave.

NOV 2 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1944, at 9 52 P.M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Late death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed body, amputation of left leg

Due to.....

Other Conditions.....
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-31-44. 7 35 P. M. 26-J
(b) Where did injury occur? Bay view Yards
(c) Did injury occur at home, on farm, industrial place, in public place Industrial While at work? yes
(d) Means of injury Crushed between R.R. cars

23. Signature Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov. 2 1944

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22193 Registered No. 937

G22193

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 400 Edgewood St.
(c) Hospital or institution:
20-7
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 35 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 400 Edgewood St. (If rural give location)
(e) Citizen of foreign country? (Yes or No). If yes, name country

3 (a) FULL NAME Jacob Harriman
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M.
5. Color or race W.
6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Agnes S. Meek
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Sept. 4, 1873
8. AGE: Years 71 Months 1 Days 26?7 If less than one day hr. min.
9. Birthplace Md. (Town, county, and state)
10. Usual Occupation Retired 10 yrs.
11. Industry or business
FATHER 12. Name Jacob Harriman
13. Birthplace —
MOTHER 14. Maiden Name Mary Vogel
15. Birthplace —
16 (a) Informant Mrs Agnes S. Harriman
(b) Address 400 Edgewood St
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 2/44 (month) (day) (year)
(c) Cemetery or crematory Loraine Pk.
Location Woodlawn, Md.
18 (a) Funeral director Harry H. Little
(b) Address 4101 Edmondson
NOV 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31/44 19 at 5 A M
21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1934 to Oct 31 1944, and that I last saw h— alive on Oct 31 19 44.

	Duration
Immediate cause of death Chronic Myocarditis	6 mo
Due to Paralysis Agitans	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature L. A. Lally
Address 3517 Edmondson Ave Date signed Nov 1/44 M. D.

VS 150

G22194

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22194 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2024 Booth St
(c) Hospital or institution: 20
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
-3 (d) Street No. 2024 Booth St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNIE E. RILEY

3 (b) If veteran, name war —

3 (c) Social Security Account No. NONE

4. Sex FEMALE | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. MARRIED

6 (b) Name of husband or wife GEORGE H. RILEY

6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) UNKNOWN

8. AGE: Years 62 | Months | Days - | If less than one day hr. min.

9. Birthplace BALTIMORE Md (Town, county, and state)

10. Usual Occupation Hw.

11. Industry or business

MOTHER / FATHER

12. Name John M. KRAFT

13. Birthplace BALTIMORE Md

14. Maiden Name ANNIE E. DAVIS

15. Birthplace BALTIMORE Md

16 (a) Informant GEORGE H. RILEY

(b) Address 2024 Booth St

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof Nov 3-1944 (month) (day) (year)

(c) Cemetery or crematory CATHEDRAL

Location City

18 (a) Funeral director Bell & B. M. Walter

(b) Address Balt & Charles Sts

19 (a) NOV 2 1944 Huntington Williams, M.D. Registrar

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1- 1944, at 1.30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-29 1944, to 11-1-1944 and that I last saw h[illegible] alive on 10-31-1944.

Immediate cause of death: arteriosclerotic myocarditis — Duration: ?

Due to: Generalized arteriosclerosis — Duration: ?

Due to: —

Other Conditions: —

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Morris B. Strueber M. D.
Address 5-48 S. Fulton Ave Date signed 11-1-44

G22195

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

937

Reg. Dist. No.

G22195

1. PLACE OF DEATH:
County 1718 Monterey Ave
City or town Balto Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 25-
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Balto City Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 1718 Monterey Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR MONTEREY yes

3. (a) FULL NAME William Wiesmann

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Margt M

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7/16 - 1888

8. AGE: Years	Months	Days	If less than one day
56	3	15	hrs. min.

9. Birthplace Balto (town, county, and state)
10. Usual occupation Gfaulfter
11. Industry or business City Employee

FATHER 12. Name Henry J Gemmer
13. Birthplace
MOTHER 14. Maiden name Cyna Hadlberg
15. Birthplace Germany
16. Informant Wife Mr.
Address 1916 Monterey Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-3-44 (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Frederick Rd
18. Funeral director Edward Lowman
Address 700 W Lexington Blvd

NOV 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1944, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 27, 1944, to October 31, 1944 and that I last saw h/M alive on October 27, 1944

Immediate cause of death Coronary Thrombosis — Interval 5 Min.
Due to Arteriosclerotic Heart Disease — YEARS
Due to
Other conditions None

(Include pregnancy within 3 months of death)

Major findings:
01 operations
01 autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Edgar F. Muller M.D. M. D. or other
Address 2628 Washington Blvd Date signed 11/1/44

463319
G22196

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 45B

G22196 Registered No. (new)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2201 Haley ton Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Charles H. Carroll

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4 Sex: Male | 5 Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-10-66

8. AGE: Years	Months	Days	If less than one day
78	-	21.	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Retired Federal Employee
11. Industry or business

FATHER
12. Name Charles Carroll
13. Birthplace Md

MOTHER
14. Maiden Name Elizabeth Campbell
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof NOV 3-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cemetery
Location Baltimore Md

18 (a) Funeral director Mamie Cook Lyfer
(b) Address 1600 W North Ave

19 (a) (b) NOV 2 - 1944
(Date rec'd by registrar) REGISTERED

Huntington Williams MD

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31, 1944 6 P.M. 45

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1944 to 19 and that I last saw h[illegible] alive on Oct 31 1944

Immediate cause of death	Duration
Coronary embolism (?)	
Due to	
Due to	
Other Conditions Recurrence of Ca of tongue and inability to talk or swallow	

(Include pregnancy within 3 months of death)

Date of operation July 29, 1944 (Specify exploratory)
Major findings of operation: Ca of Tongue
of autopsy: NA obtained

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Handelsman M. D.
Address [illegible] Date signed 10-31-44

G22197

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

Registered No. G22197

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 541 N. Mechanic St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 541 N. Mechanic St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth Prentiss

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Algerman

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-18-1889

8. AGE: Years 55 | Months 8 | Days 12 | If less than one day hr. min.

9. Birthplace Belair, Md.
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Theodore Saunders
13. Birthplace Belair, Md.

MOTHER
14. Maiden Name Louise ??
15. Birthplace Belair, Md.

16 (a) Informant Algerman Prentiss
(b) Address 541 N. Mechanic St

17 (a) Buried (b) Date thereof Nov. 4, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Pk.
Location Balto. Co. Md.

18 (a) Funeral director Wm. George W. Holland
(b) Address 1631 Druid Hill Ave
Huntington Williams, M.D.

NOV 2 - 1944 (Registrar)
(Date rec'd by Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-30- 1944 at 4:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 7-1-41 19 to 10-30 1944.
and that I last saw her alive on 10-30 1944.

Immediate cause of death	Duration
Due to Cardiac failure	2 days
Due to Mitral insufficiency	3 years
Other Conditions Hypertension.	

(Include pregnancy within 3 months of death)

Date of operation None.
Major findings of operation: None
of autopsy: No

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Harry E. Hamm M. D.
Address 2340 Madison Ave Date signed 11-2-44

G22198

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 161C

Registered No. G22198

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: UNIVERSITY HOSPITAL 17-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) from Nov. 16th to Nov. 2nd
(e) Length of stay in Baltimore (yrs., mos., or days) 11 wks.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 605 Brune St. (If rural give location)
(e) Citizen of foreign country? NO (Yes or No) If yes, name country

3 (a) **FULL NAME** Leroy Young
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8/10/44

8. AGE: Years	Months	Days	If less than one day
	2	21	hr. min.

9. Birthplace BALTIMORE, MARYLAND (Town, county, and state)
10. Usual Occupation NONE
11. Industry or business NONE

FATHER
12. Name DAVID YOUNG
13. Birthplace S.C.

MOTHER
14. Maiden Name FRANCES MARTIN
15. Birthplace S.C.

16 (a) Informant MOTHER
(b) Address 605 BRUNE ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Thos. Geo. A. Stallard
(b) Address 1610 Druid Hill Ave.

NOV 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-31 1944, at 2:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1944, to 10-31 1944, and that I last saw him alive on 10-31 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Lupus erythematosus	
Due to Acute jaundice	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas G. Ellis M. D.
Address Univ. Hosp. Date signed 10-31-44

VS 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

G22199

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

Registered No. G22199

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 652 W Lee St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 22-2
(e) Length of stay in Baltimore (yrs.) mos., or days) 25

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 652 W. Lee St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John Brooks

3 (b) If veteran, name war —
3 (c) Social Security Account No.

4. Sex male | 5. Color or race Col | 6 (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Mary Brooks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 1891

8. AGE: Years 53 | Months 6 7 | Days | If less than one day hr. min.

9. Birthplace Danville Va (Town, county, and state)

10. Usual Occupation Labor

11. Industry or business

FATHER
12. Name Elisha Brooks
13. Birthplace Va

MOTHER
14. Maiden Name Maria Glenn
15. Birthplace Va

16 (a) Informant William Brooks (Son)
(b) Address 834 Warner St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location Balto. Co. Md

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 101 W Montgomery St

NOV 2 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/44 19 , at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/16 19 44 to 10/30 19 44.
and that I last saw h alive on 10/29 19 44

Immediate cause of death acute Lobar Pneumonia

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David Drucker M. D.
Address 1114 Lee Date signed NOV 1/45

G22200

AB- 90338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22200 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals 26-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 37 min.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 520 Reppolle St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy (Lillian Hayes) Gietka

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 22-1944

8. AGE: Years	Months	Days	If less than one day
		1	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Bernard F. Gietka
13. Birthplace

MOTHER
14. Maiden Name Lillian Hayes
15. Birthplace

16 (a) Informant Baltimore City Hospitals (Records
(b) Address 4940 Eastern Ave.

17 (a) [redacted], cremation, [redacted] (b) Date thereof 10-28-44 9 A.M.
(month) (day) (year)
(c) [redacted] crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

NOV 2 - 1944 (Date rec'd by registrar) (Huntington Williams, M.D.) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 22- 1944, at 5.12 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-22- 1944, to 10-22- 1944, and that I last saw h im alive on 10-22- 1944.

Immediate cause of death Pneumothorax

Due to —

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy: —

Duration
1 hr. min.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Ellis Fleet M. D.
Address Baltimore City Hosp. Date signed 10-27-44

G22201

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

9

G22201
Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 17-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 580 St Marys St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Marcel Smith

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Black	S

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/22/41

8. AGE: Years	Months	Days	If less than one day
3	-	9	hr. min.

9. Birthplace Va (Town, county and state)
10. Usual Occupation Child
11. Industry or business

FATHER
12. Name Levi C. Smith
13. Birthplace Va

MOTHER
14. Maiden Name Bessie Jackson
15. Birthplace Va

16 (a) Informant Records.
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Md

18 (a) Funeral director Geo. H. Kelson
(b) Address 203 Penhurst Ave

NOV 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION D

20. DATE OF DEATH Oct. 31 1944 at 5.45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1944 to Oct 31 1944, and that I last saw her alive on Oct 31 1944.

Immediate cause of death	Duration
Respiratory failure	
Due to Pneumonia	4 days
Due to	
Other Conditions Partussis	14 days

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy Anatomical Diag. 11/1/44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Paul E. Wilson M. D.
Address Johns Hopkins Hosp Date signed 10/31/44

G22202

AB-90361

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

95B

Registered No. G22202

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 14-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 1/2yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1711 Madison Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: George Vick

3 (b) If veteran, name war: —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	C	Single

6 (b) Name of husband or wife S

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 10-1916

8. AGE: Years	Months	Days	If less than one day
28	4	12	hr. min.

9. Birthplace N.C. (Town, county, and state)

10. Usual Occupation —

11. Industry or business

MOTHER | FATHER

12. Name George Vick (D)

13. Birthplace ?

14. Maiden Name Julia Dickens (D)

15. Birthplace ?

16 (a) Informant Records Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location Md.

18 (a) Funeral director Wes. G. Nelson

(b) Address 1303 Pennsylvania Ave. Huntington Williamsport

NOV 2 - 1944 (Date rec'd by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1944, at 2.55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1944, to 10-31 1944, and that I last saw him alive on 10-31 1944.

Immediate cause of death Substernal subcutaneous Emphysema

Due to Staphylococcus Infection

Due to Pneumonia due to unknown organism

Other Conditions Chronic Rheumatic Heart disease, Cardiac failure

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: as above

Duration
7
7
?
?

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide —

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature D. M. Phillips M. D.

Address Baltimore, Md. Date signed 11-1-44

G22203

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G22203

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physician: please correct age is especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2108 Erdman Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) ---
(e) Length of stay in Baltimore (yrs., mos., or days) About 91 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County --------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2108 Erdman Avenue (If rural give location)
(e) Citizen of foreign country? -------- (Yes or No)
If yes, name country --------

3 (a) FULL NAME Mary Agnes McCarthy

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --------
6 (c) If alive, give age -- years
7. Birth date of deceased (mo., day, yr.) ----------

8. AGE: Years	Months	Days	If less than one day
About 91	---	---	-- hr. --- min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name John McCarthy
13. Birthplace Ireland

MOTHER
14. Maiden Name Johannah Kelleher
15. Birthplace Ireland

16 (a) Informant Mrs. Mary C. Burns
(b) Address 2108 Erdman Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 NOV 2 - 1944 (Date rec'd by registrar) [signature] Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31st 1944, at 7.55 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944 to October 1944, and that I last saw her alive on October 30 1944

Immediate cause of death Carcinoma of

Due to the breast of

Due to general metastases

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

Duration

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address 3005 St Paul St. Date signed 11-1-44

G22204

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22204

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item or information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1500 Myrtle Ave
(c) Hospital or institution: 14

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Johnson

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1500 Myrtle Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie A Turner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-6-1895

8. AGE: Years	Months	Days	If less than one day
49	2	24	hr. min.

9. Birthplace S.C.
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER	12. Name Wm. Goldsmith
	13. Birthplace S.C.
MOTHER	14. Maiden Name ?
	15. Birthplace ?

16 (a) Informant Verdie Hammonds
(b) Address 1500 Myrtle Ave

17 (a) Burial (b) Date thereof 11-6-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md

18 (a) Funeral director William A. Jackson
(b) Address 916 Penna. Ave

NOV 2 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 1944 4:30 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Brooke Hundley M.D.
Medical Examiner.
Date signed 11/2/44

G22205

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

TN. 90124

Registered No. G22205

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution: Baltimore City Hospitals 5-2
(d) Length of stay in hospital or inst. (yrs., mos., or days) 25 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 518 N. Gay St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN ARNOLD HUBBARD

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Sept.

6 (b) Name of husband or wife Edna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1889

8. AGE: Years 55 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Maryland (Balto.) (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business H.

FATHER
12. Name William Hubbard
13. Birthplace Maryland (Baltimore)

MOTHER
14. Maiden Name Mary Underhill
15. Birthplace Maryland (Snow Hill)

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 NOV 2 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION 11.50 A

20. DATE OF DEATH November 1st 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-5- 1944 to 11-1- 1944, and that I last saw him alive on 11-1-44 19

Immediate cause of death Sudden Death — Duration

Due to ureteral Cancer

Due to (over)

Other Conditions arteriosclerotic Heart Disease 7 y
Congestive failure. Pulmonary Tbc?
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence 4?8 at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. M. Kelly M. D.
Address Balt. City Hosp. Date signed 11-1-44

To be approved by Medical Examiner

G22206

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22206 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3326 ELMLY AVE.
(c) Hospital or institution: 1-3
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County BALTO.
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 519 S. BELNORD AVE. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME MARY MENZEL

3 (b) If veteran, name war: NO
3 (c) Social Security Account No.: NONE

4. Sex: FEMALE
5. Color or race: WHITE
6 (a) Single, married, widowed, or divorced: WIDOW

6 (b) Name of husband or wife: GEORGE MENZEL
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): DEC. 6 1865

8. AGE: Years 78 | Months 9 | Days 25 | If less than one day hr. min.

9. Birthplace: BALTIMORE MD (Town, county, and state)
10. Usual Occupation: HOUSE WIFE
11. Industry or business: AT HOME

FATHER
12. Name: UNKNOWN
13. Birthplace: GERMANY

MOTHER
14. Maiden Name: UNKNOWN
15. Birthplace: GERMANY

16 (a) Informant: MRS. CHARLES RAU (DAUGHTER)
(b) Address: 3326 ELMLY AVE.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 4/44 (month) (day) (year)
(c) Cemetery or crematory: PARK WOOD
Location: TAYLOR AVE.

18 (a) Funeral director: Lilly & Zeiler Inc
(b) Address: 403 S. WOLFE ST.

19 (a) (Date rec'd by Registrar) (b) Registrar

NOV 2 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 1 1944, at 6/30 AM.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1944 to Nov 1 1944.
and that I last saw h alive on Oct 31 1944

Immediate cause of death: Hypertension
Due to: Cardio
Due to: Vascular Renal
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy: Acute Cerebral Thrombosis

Duration: Fatal

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: Huntington Williams M.D.
Address: 100 W. Biddle St. Date signed: 11/2/44

Huntington Williams, M.D.

G22207 AB-90589

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1192a

G22207 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 1-3

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 628 S. Milton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Stanley Swiecicki ✓

3 (b) If veteran, name war	3 (c) Social Security Account No.
NO	NONE

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15-1944

8. AGE: Years	Months	Days	If less than one day
	1	16	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation NONE

11. Industry or business

FATHER

12. Name Stanley Swiecicki

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Emma Weiss

15. Birthplace Baltimore, Md.

16 (a) Informant Records) Baltimore City Hospitals

(b) Address 4940 Eastern Ave.

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 2/44 (month) (day) (year)

(c) Cemetery or crematory SACRED HEART

Location GERMAN HILL ROAD

18 (a) Funeral director Lilyand Geeler INC

(b) 403 S. Monroe St. Williamsport, Md.

19 (a) NOV 2 - 1944 (b)

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1944, at 3.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-25-44 19 to 10-31- 1944, and that I last saw h Live alive on 10-31 1944.

	Duration
Immediate cause of death Respiratory failure	
Due to Septic Infection of Uterus Cancer	life
Due to Pelvic Media	0 Yrs. 5 mos.
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ellis Fear M. D.

Address Baltimore City Hosp. Date signed 11-3-44

VE 180

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22208

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 c

G22208 Registered No.

PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 1027 Light St.
(c) Hospital or institution:

15-12

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3813 Reisterstown Road (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME: CELIA FRIED

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife Joel Fried
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 2, 1886.

8. AGE: Years	Months	Days	If less than one day
58	9	29	hr. min.

9. Birthplace ? (Town, county, and state)
10. Usual Occupation Saleslady: Music Store
11. Industry or business

FATHER
12. Name David Reese,
13. Birthplace ?.

MOTHER
14. Maiden Name Rachel Goodman,
15. Birthplace ?.

16 (a) Informant Mr. Arthur Rose,
(b) Address 3813 Reisterstown Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44. (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Balto. Md.

18 (a) Funeral Chas. Sonneborn & Sons
(b) Address 1902 Eutaw Place.

NOV 2 - 1944 (Date rec'd by registrar) (b) Huntington Williams, Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1st. 1944, at P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 7 1944 to Oct 27 1944, and that I last saw her alive on Oct 27 1944.

Immediate cause of death	Duration
Coronary thrombosis	Suddenly
Due to Rheumatic endocarditis	3 years
Due to	
Other Conditions (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Frederick Lantz M. D.
Address Temple Garden Apts Date signed 11/2-44

G22209 G22209

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 N. Fulton Ave.
(c) Hospital or institution: 15-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1927 N. Fulton Ave. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Belle H. Sternheimer

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	white	Widow

6 (b) Name of husband Benjamin Sternheimer
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1871

8. AGE: Years	Months	Days	If less than one day
72	11	21	hr. min.

9. Birthplace Port Deposit Md. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Robert H. Donaldson,
13. Birthplace Scotland

MOTHER
14. Maiden Name Mary Crothers
15. Birthplace Ireland

16 (a) Informant Mrs. Gorman,
(b) Address Wilmington Del.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Chev Shalom
Location Balto. Md.

18 (a) Funeral director Hennessey & Son
(b) Address 1062 Eutaw Place

19 (a) (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/44 19 , at 2:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 1940 to 10/30 19 44, and that I last saw h. alive on 10/30/44 19

Immediate cause of death Arteriosclerosis

Due to

Due to

Other Conditions Diabetes Mellitus

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Herman Gorman M. D.
Address 1816 W North Ave Date signed 11/1/44

VS 8

G22210

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

V 30 B

G22210

Registered No.

Va-90271

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 19-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 Edmondson Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert J. May

3 (b) If veteran, name war	3 (c) Social Security Account No.
Yes	

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Married

6 (b) Name of husband or wife Bernice
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1894

8. AGE: Years	Months	Days	If less than one day
50	5	13	hr. min.

9. Birthplace (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Albert May
13. Birthplace Alabama

MOTHER
14. Maiden Name Susie ?
15. Birthplace Alabama

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Burial (b) Date thereof 11/2/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location

18 (a) Funeral director Saml. W. Cheek & Son
(b) Address 638 N. Gilmor St.

19 (a) NOV 2 - 1944 (b) Registrar Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31, 1944, at 11:15 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-18 1944 to 10-31 1944 and that I last saw him alive on 10-31 1944.

Immediate cause of death Pulmonary Embolus — Duration

Due to Thrombosis of superior segital sinus

Due to

Other Conditions Tabeo-paresis

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Benson Jr. M. D.
Address City Hosp. Date signed 10/11/44

VS 150

G22211

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22211 Registered No. 1131a

PLACE OF DEATH:
Baltimore City, Maryland
(b) Street address 2127 N. Smallwood St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2127 N. Smallwood
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Sophie Cohen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Philip -
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years: 77 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual Occupation: Housewife

11. Industry or business

FATHER
12. Name: Brag -
13. Birthplace: Russia

MOTHER
14. Maiden Name: Shifra -
15. Birthplace: Russia

16 (a) Informant: Family Records
(b) Address: 2127 N. Smallwood St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-2-44 (month) (day) (year)
(c) Cemetery or crematory: Balto. Hebrew
Location:

18 (a) Funeral director: Jack Levin Inc
(b) Address: 1439 E. Balto. St

19 (a) NOV 2 1944 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2-44 19 , at 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from June 1940 to 11/2 1944, and that I last saw alive on 11/2 1944.

Immediate cause of death	Duration
Cardio-Renal Vascular Disease	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:
23. Signature: Benj. Samuels M.D.
Address: 2128 W. North Ave Date signed 11/3/44

Hearing to Mitchell

VS 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FO... BLANK.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

G22212

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22212

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 257 N. Bruce st
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 19-2
(e) Length of stay in Baltimore (yrs., mos., or days) 30 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 257 N. Bruce st (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rosie Watts

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
F	Col	Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-15-1891

8. AGE: Years	Months	Days	If less than one day
53	8	15/16	hr. min.

9. Birthplace St Marys Co - Md (Town, county, and state)
10. Usual Occupation House wife
11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Charles Watts
(b) Address 1726 N. Franklin st

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 3 44 (month) (day) (year)
(c) Cemetery or crematory Arbutus Mem. Cem
Location Arbutus Md

18 (a) Funeral director William A Jackson
(b) Address 916 Pemberton

19 NOV 2 - 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944 at 7 a.m.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1944 to Oct 31 1944 and that I last saw h[illegible] alive on Oct 31 1944

Immediate cause of death	Duration
Congestive Heart Failure	3 weeks
Due to Arteriosclerotic Heart Disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ralph W. Pickett M.D.
Address 716 N. Johns st Date signed Nov 1 44

G22213

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22213 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 801 S.Robinson St.
(c) Hospital or institution: —

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 801 S.Robinson St.
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME John Kleylein

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Elise Murmann
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.14,1855

8. AGE: Years	Months	Days	If less than one day
88	11	17	hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name Frank
13. Birthplace Germany

MOTHER
14. Maiden Name not known
15. Birthplace Germany

16 (a) Informant Wife
(b) Address 801 S.Robibson St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov.3,44 (month) (day) (year)
(c) Cemetery or crematory Schwartz
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway

19 (a) NOV 2 1944 (Date received by Registrar) (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct.31, 1944, at 1p M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 12 1942, to Oct 31 1944 and that I last saw h alive on Oct 31 1944.

	Duration
Immediate cause of death Arteriosclerotic C.V. Disease	Oct 11/44
Myocardial Failure	
Due to	
Due to	
Other Conditions None.	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ?
(b) Date of occurrence None. at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature E.A. Schumacher M. D.
Address 842 S. Eastern Ave Date signed 11-1-44

G22214

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22214 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2931 E.Balto. St.
(c) Hospital or institution: 1 - 2
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2931 E.Balto. St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank J.Shutz

3 (b) If veteran, name war: --
3 (c) Social Security Account No.: --

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Aurelia Shutz
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan.2,1876

8. AGE: Years 68 | Months 9 | Days 29 | If less than one day hr. min.

9. Birthplace Balto.Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Wm.Shutz
13. Birthplace Va.

MOTHER
14. Maiden Name Margaret Otto
15. Birthplace Balto.Md.

16 (a) Informant Mrs.Aurelia Shutz
(b) Address 2931 E.Balto.St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov.3,1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redemeer Cem.
Location Balto.Md.

18 (a) Funeral director Philip Sterling Sons
(b) Address 2024 Orleans St.

19 NOV 2 - 1944 (Date received by registrar) Huntington for Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct.31 /44, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Mar 1944, to Oct 30 1944, and that I last saw h[illegible] alive on Oct 30 1944

Immediate cause of death: Acute Cardiac dilatation — Duration: 24 hrs.

Due to: Arteria sclerotic cardio vascular disease — Duration: Several years

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Anthony J. Sirna M. D.
Address 4600 York Rd Date signed 11/1/44

G22215

TA-90315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G22215

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Avenue

(c) Hospital or institution: BALTIMORE CITY HOSPITALS 7-5

(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 hrs.

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Belto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 1539 E. Monument (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** Baby Girl Howard

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1944

8. AGE: Years | Months | Days | If less than one day: 8 hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Newborn

11. Industry or business

FATHER

12. Name Leroy Howard

13. Birthplace N. C.

MOTHER

14. Maiden Name Beulah Griffin

15. Birthplace Md.

16 (a) Informant BALTIMORE CITY HOSPITALS

(b) Address (RECORDS)

17 (a) [redacted] (b) Date thereof 10-28-44 9; A.M. (month) (day) (year)

(c) [redacted] crematory Baltimore City Hospitals

Location 4940 Eastern Ave (Records

18 (a) Funeral director

(b) Address

19 NOV 2 - 1944 Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH October 20, 1944, at 11:10 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/20 1944 to 10/20 1944.

and that I last saw h[redacted] alive on 10/20 1944

Immediate cause of death: Intra-cranial hemorrhage — Duration: 7 hrs.

Due to: Labor.

Due to:

Other Conditions: Prematurity

(Include pregnancy within 3 months of death)

Date of operation: —

Major findings of operation: —

of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. Edwards Jr. M. D.

Address BCH Date signed

C22216
YA-90342

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

160a

Registered No. C22216

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 3 — 1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S. Bond St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams (B)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Newborn

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1944

8. AGE: Years | Months | Days | If less than one day 9hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie Williams
13. Birthplace N. C.

MOTHER
14. Maiden Name Carrie White
15. Birthplace N. C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) [redacted] cremation, [redacted] (b) Date thereof 10-28-44 9 A.M.
(month) (day) (year)
(c) [redacted] crematory Baltimore City Hospitals
Location 4940 Eastern Ave. (Records)

18 (a) Funeral director
(b) Address

19 NOV 2 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 23, 1944 (Mo.), at 2:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 19 44 to 10/23 19 44.
and that I last saw h/me alive on 10/23 19 44.

Immediate cause of death: INTRACRANIAL Hemorrhage — Duration 9 hr.
Due to: BIRTH INJURY
Due to:
Other Conditions: PREMATURITY
(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. H. Perry, Jr. M.D.
M. D.
Address Balto City Hosp Date signed 10/27/44

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22217

YA-90341

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

160a

Registered No. G22217

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 3-
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 1
(If outside city or town limits, write RURAL and give town)
(d) Street No. 104 S. Bond Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Williams (A)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Newborn

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 22, 1944

8. AGE: Years | Months | Days: 1 | If less than one day: 11 hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Willie Williams
13. Birthplace N. C.

MOTHER
14. Maiden Name Carrie White
15. Birthplace N. C.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) [redacted] cremation, [redacted] (b) Date thereof 10-28-44 9: A M
(month) (day) (year)
(c) [redacted] crematory Baltimore City Hospitals
Location 4940 Eastern Ave (Records

18 (a) Funeral director
(b) Address

19 (a) NOV 2 - 1944 (Date rec'd by registrar) (b) Tunstall Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH October 24, 1944, at 3:40 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 19 44 to 10/24 19 44, and that I last saw h[illegible] alive on 10/24 19 44

Immediate cause of death: Intra-Cranial Hemorrhage — Duration

Due to: Labor

Due to:

Other Conditions: Prematurity

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Donald Jr. M.D.

Address B.C.H. Date signed 10/27/44

G22218

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

G22218 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully ... The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 22 N. Eden St.
(c) Hospital or institution: 5-1
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 22 N. Eden St. (If rural give location)
(e) Citizen of foreign country? No. (Yes or No) If yes, name country

3 (a) FULL NAME Mary E. T. Muhler

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 7, 1875

8. AGE: Years 68 | Months 10 | Days 23 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name August Muhler
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Seidel
15. Birthplace ?

16 (a) Informant Mr. Charles Muhler
(b) Address 22 N. Eden St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 44 (month) (day) (year)
(c) Cemetery or crematory Immanuel Cem.
Location Grindon Lane

18 (a) Funeral director L. Heemann and Son
(b) 2 Broadway

19 (a) NOV 2 1944 (Date rec'd by registrar) (b) Signature of Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1944 at 10 PM

21. I certify that death occurred on the date above stated; that I attended deceased from June 1941 to Oct 31 1944, and that I last saw ... alive on Oct 31 1944.

Immediate cause of death Cardio Vascular Renal Disease — Duration 3 yrs.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. H. Heemann
Address 436 E Fort Ave Date signed 11/1/44

Huntington Williams, M.D.

G22219

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 82

G22219 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 14-3
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 581 Pratman (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Maggie Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	negro	Widowed

6 (b) Name of husband or wife Edward Smith 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1/24/1885

8. AGE: Years	Months	Days	If less than one day
59	9	7	hr. min.

9. Birthplace Clarksville, Ga. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Wildstein Black
13. Birthplace Ga

MOTHER
14. Maiden Name ?
15. Birthplace ?

16 (a) Informant Emma Christian
(b) Address 581 Pratman St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8-44 (month) (day) (year)
(c) Cemetery or crematory
Location Social, Ga.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison ave.

Filed NOV 2 1944 Huntington Williams M.D. Registrar

V8 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 19 44 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 2 19 44 to Nov. 1 19 44 and that I last saw h[illegible] alive on Nov 1 19 44

Immediate cause of death: Myocardial Failure
Due to: Chronic Nephritis
Due to: Transverse Myelitis
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature G. H. Campbell
Address Provident Hospital Date signed 11/1/44

G22220

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22220

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Eaton & Wilkens
(c) Hospital or institution: St. Agnes Fthoria Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 426 Frederick Ave (If rural give location)
(e) Citizen of foreign country? --NO---------- (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Thornberg (Elizabeth C.)

3 (b) If veteran, name war --
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: Single ---
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEB. 7 - 1891

8. AGE: Years 53 | Months 8 | Days 24 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name William J. Thornberg
13. Birthplace Hagerstown, Maryland

MOTHER
14. Maiden Name Mary E. Curran
15. Birthplace Baltimore, Maryland

16 (a) Informant Mrs. Rose T. Moyers
(b) Address 4700 Frederick avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/44 (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location

18 (a) Funeral director Chas. L. Evans, Son Inc
(b) Address 118 N. Mt. Royal Ave

NOV 2 - 1944 (Date rec'd by Registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 1944, at 10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1944 to 11-1 1944, and that I last saw her alive on 11-1 1944.

Immediate cause of death: Cerebral Hemorrhage
Due to: Cardiac & Respiratory failure
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Cleff Ratliff, Jr. M. D.
Address St Agnes Hosp Date signed 11-1-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Special age is especially important. MARGIN RESERVED FOR BINDING

G22221

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22221 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2101 N Caroline Lane
(c) Hospital or institution: 27-15

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Jane Houseman

3 (b) If veteran, name war — 3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Theodore

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20 1859

8. AGE: Years 84 | Months 11 | Days 11 | If less than one day hr. min.

9. Birthplace Pa (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Augustus Hahn
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Sally Workman
15. Birthplace Germany

16 (a) Informant Rumin A Houseman
(b) Address 3619 Raymond Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location York Rd & Lake Ave

18 (a) Funeral director Wilson & Son
(b) Address 1219 W Lanvale St

19 (a) (Date filed) (b) Registrar

NOV 2 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944, at 8:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 28 1944 to Oct 31 1944, and that I last saw h-r alive on Oct 31 1944

Immediate cause of death: Chronic Myocarditis — Duration

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. K. Patterson

Address 7314 Reisterstown Rd Date signed 11/1/44

G22222

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22222 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2914 Prestman St
(c) Hospital or institution: Univ. Hospital 16 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore, Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cerita E Straub

3 (b) If veteran, name war —

3 (c) Social Security Account No. none

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Hans J. Straub

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1901 Feb 18

8. AGE: Years 43 | Months 8 | Days 14 | If less than one day hr. min.

9. Birthplace Pittsburg, Pa (Town, County, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER 12. Name John Boeard

13. Birthplace Pittsburg Pa

MOTHER 14. Maiden Name Annie O'Neal

15. Birthplace Ireland

16 (a) Informant Hans Straub

(b) Address 2914 Prestman St

17 (a) Funeral (Burial, cremation, or removal) (b) Date thereof 11/2/44 (month) (day) (year)

(c) Cemetery or crematory Greenwood

Location Pittsburgh Pa

18 (a) Funeral director Wilson Funeral Home

(b) Address 1210 Park Ave

19 (a) (Delivered by registrar) (b) Registrar

VS 10 NOV 2 - 1944 Huntington, West Virginia

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2 1944 at 2:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1944 to 10/31 1944 and that I last saw h alive on 19

Immediate cause of death Rt heart failure.

Due to

Due to

Other Conditions Pa. Wellens anemia
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Ernest F. Lang M. D.

Address Univ Hosp Date signed 11-2/44

G22223

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95c

G22223 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2247 W. Baltimore St
(c) Hospital or institution: 20-4
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2247 W. Balto. St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gus Poletis

3 (b) If veteran, name war: N
3 (c) Social Security Account No. 1045

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Pare
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. Age: Years	Months	Days	If less than one day
46 68			hr. min.

9. Birthplace Turkey (Town, county, and state)
10. Usual Occupation Chef
11. Industry or business

FATHER
12. Name George Poletis
13. Birthplace Unknown

MOTHER
14. Maiden Name Mary "
15. Birthplace "

16 (a) Informant George Rousaos
(b) Address 702 St. Paul St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or cemetery Greek Orthodox
Location Windsor Mill Road

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul St

19 (c) Nov 2 1944
Registered by

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31st 1944, at 2:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Oct 31 1944 and that I last saw him alive on 10/31 1944.

Immediate cause of death Coronary Thrombosis

Duration
2 yrs

Due to Hypertension

Due to Hypertrophied Heart

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Chas A Cohn M. D.
Address 2145 W Balto St Date signed

G22224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 57d

Registered No. G22224

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Hayward & Dukeland
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 min.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4118 Pimlico Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Theresa Lahn

3 (b) If veteran, name war

3 (c) Social Security Account No. 215-01-6140

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years	Months	Days	If less than one day
49			hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation

11. Industry or business Examiner Schloss Bros

FATHER
12. Name Abraham Lahn
13. Birthplace Russia

MOTHER
14. Maiden Name Rebecca Miller
15. Birthplace Russia

16 (a) Informant Charles Lahn
(b) Address 2602 Quantico Ave

17 (a) Burial (b) Date thereof Nov, 3, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124-1126 W North Ave

19 (a) NOV 2 - 1944 (b) Washington Williams, M.D. Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1944, at 7:15 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1944, to Nov 2 1944, and that I last saw h. alive on Nov 2 1944.

Immediate cause of death Respiratory & Cardiac failure

Due to Brain Tumor

Due to (a)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm H Baldwin M. D.
Address West Bal. Gen Hosp Date signed 11-3-44

G22225

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

Registered No. G22225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wilkens Ave.
(c) Hospital or institution: St Agnes Hosp. 28
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(d) Street No. 5309 (If outside city or town limits, write RURAL and give town) ~~5341~~ Liberty Heights Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hazel H. Heagey

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Clarence A. Heagey
6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.): December 10, 1892

8. AGE: Years	Months	Days	If less than one day
51	10	21	hr. min.

9. Birthplace: Gettysburg, Pa. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business: At Home

FATHER
12. Name: Charles Kennell
13. Birthplace: Gettysburg, Pa.

MOTHER
14. Maiden Name: ? Dull
15. Birthplace: Gettysburg, Pa.

16 (a) Informant: Mr. Clarence A. Heagey
(b) Address: 5509 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 3, 1944 (month) (day) (year)
(c) Cemetery or crematory: Evergreen Cemetery
Location: Gettysburg, Pa.

18 (a) Funeral director: E. L. Lawrence
(b) Address: 4510 Liberty Heights Ave.

19 (a) NOV 2 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1944, at 1 10 P M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Crushed pelvis; partial evisceration of abdomen

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 53-00 5M
(a) Date of injury Oct. 31 1944 12 P M.
(b) Where did injury occur? Route #40 & Highland Ave.
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Collision of autos.

23. Signature Robert L. Slaughter M.D. Medical Examiner.
Date signed Oct. 31 1944

VS 181

G22226

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22226 94a

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1431 S Charles St
(c) Hospital or institution: 23-2

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto City (If outside city or town limits, write RURAL and give town)
(d) Street No. 1431 S Charles St (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret E. Leffler

3 (b) If veteran, name war No
3 (c) Social Security Account No. No

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife John Leffler
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 1867

8. AGE: Years 77 | Months 1 | Days 8 | If less than one day hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation At Home
11. Industry or business

FATHER
12. Name Daniel E Spedden
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Wilken
15. Birthplace Md

16 (a) Informant Laura V. Lambdin
(b) Address 1431 S Charles St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 1944 (month) (day) (year)
(c) Cemetery or crematory Mt Carmel
Location Balto City

18 (a) Funeral director A. Poole & Sons
(b) Address 1400 S Charles St

Dated Nov 2 1944 (b) Huntington Williams M.D.
VS 11e

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1, 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Nov 1 1944
and that I last saw her alive on Oct 31 1944

Immediate cause of death: Cardiac thrombosis — Duration 1 day
Due to: Senile Bronchitis — 15 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Howard Lamb M. D.
Address Date signed

G22227 ✓ G22227

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

Registered No. .....

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 59 W. West St.
(c) Hospital or institution: .....
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 [illegible]
(e) Length of stay in Baltimore (yrs., mos., or days) 44 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Balto (If outside city or town limits, write R.F.D. number, name of township, or village.)
(d) Street No. 59 W. [illegible] St. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME John W. Foster ✓

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	Col'd	—

6 (b) Name of husband or wife —
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June - 1901

8. AGE: Years	Months	Days	If less than one day
43	10	-	..... hr. ..... min.

9. Birthplace A.A. Co. Md (Town, county, and state)
10. Usual Occupation laborer
11. Industry or business

FATHER
12. Name Wm Foster
13. Birthplace md

MOTHER
14. Maiden Name alice Day
15. Birthplace md.

16 (a) Informant Cora Washington
(b) Address 59 W. West St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6-44 (month) (day) (year)
(c) Cemetery or crematory Byers Cemetery
Location Annapolis. Md

18 (a) Funeral director James Costagen
(b) Address 142 W. West St

19 (a) NOV 3 1944 (Date received by Registrar) (b) Huntington Williams, Md

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1944, at 10 45 a. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 20 1944 to Nov 1 1944 and that I last saw h[illegible] alive on Oct 31 1944

Immediate cause of death	Duration
acute Bronchitis	1 w 2d
Due to pneumonia	
Due to	
Other Conditions mental case	

(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature [illegible] M.D.
Address [illegible] Date signed 11/4/44

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22228

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22228 Registered No. 490

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stony Run Lane
(c) ~~Hospital or~~ institution:
Dr McKenna Clinic
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Phoenix
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rural
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Gertrude Estelle Brown

3 (b) If veteran, name war W
3 (c) Social Security Account No. none

4. Sex Female | 5. Color or race White | 6 (a) ~~Single~~, married, ~~widowed, or divorced~~ Married

6 (b) Name of husband Unknown (Brown)
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years 72 | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation Companion
11. Industry or business Household

FATHER
12. Name John Brown
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Charlotte Brady
15. Birthplace Balto. Md.

16 (a) Informant Mrs Charles Burgan
(b) Address 2512 N. Calvert St

17 (a) Burial (b) Date thereof 11/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Cathedral
Location Balto. Md.

18 (a) Funeral director William Cook
(b) Address 1217 E. Baltimore St.

19 (a) NOV 3 1944 (b) Entered in Register

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1944 at 3:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Mar. 1944 to 11/1 1944 and that I last saw her alive on 11/1 1944.

Immediate cause of death Carcinomatosis — Duration 9 mos.
Due to Primary Carcinoma Rt. ovary. — ?
Due to Metastasis to 5th lumbar vertebrae — 9 mos.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Robert H. Siver M.D.
Address Cockeysville, Md. Date signed 11/3/44
ROBERT H. SIVER

G22229 ✓ G22229

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131B

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1138 Montegalish St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward J. O'Brien

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of ~~husband or~~ wife: Annie E. O'Brien

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4th 1884

8. AGE: Years 60 | Months 1 | Days 28 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business ——

FATHER
12. Name (Unknown) O'Brien
13. Birthplace Balto. Md.

MOTHER
14. Maiden Name Harrison
15. Birthplace Balto. Md.

16 (a) Informant Catherine E. Sipes
(b) Address 1138 Montegalish St.

17 (a) Burial (b) Date thereof 11/4/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or ~~crematory~~ Morland Park
Location Parkville Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St Paul St.

19 (a) NOV 3 1944 (c) Huntington Williams M.D.
Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1944, at 4:30 A M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to ~~his~~ death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Acute Congestive Cardiac Failure

Due to

Other Conditions Arter. Scl. Hyperten. Fibrosis Chr. Nephritis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Mueller M.D.
Medical Examiner.
Date signed 11-2-44

Dr. L. B. Stevens
3400 Erdman Avenue
G22230

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 49a

Registered No. G22230

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3170 Ravenwood Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3170 Ravenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary V. Keidel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Frank Keidel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 8, 1894

8. AGE: Years 50 | Months 8 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Michael Rinaldi
13. Birthplace Italy

MOTHER
14. Maiden Name Mary Messina
15. Birthplace Italy

16 (a) Informant Mrs. Frank Keidel
(b) Address 3170 Ravenwood Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road #14

19 (a) (Date received by registrar) (b) Registrar

NOV 3 - 1944 Huntington Hillcrest

VS 1

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1944, at 5:50 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/10/44 19__, to 10/31 1944, and that I last saw her alive on 10/31 1944.

Immediate cause of death: Cardiac Failure. — Duration: 1 yr.
Due to: Metastatic carcinoma of ovary, bilateral.
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation January 1944.
Major findings of operation: Adeno-Carcinoma of ovary, bilateral with metastasis.
Date of autopsy: (None)

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature L B Stevens M.D.
M.D.
Address 3400 Erdman Ave. Date signed 11/2/44

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

G22231

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

91a

Registered No. G22231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hosp. 20
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. OA.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Woodington Road (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME: Blanche Lyles

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: F | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Harry Lyle

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 1, 1898

8. AGE: Years 46 | Months 6 | Days 30 | If less than one day hr. min.

9. Birthplace: Howard Co Md. (Town, county, and state)

10. Usual Occupation: Domestic

11. Industry or business

FATHER
12. Name: Frank Howard
13. Birthplace: Md.

MOTHER
14. Maiden Name: Harriett Anderson
15. Birthplace: Md.

16 (a) Informant: Louis Howard
(b) Address: Dayton Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-44 (month) (day) (year)
(c) Cemetery or crematory: Brown's Chapel
Location: Dayton Md.

18 (a) Funeral director: J.C. Higinbotham
(b) Address: Ellicott City Md

19 (a) NOV 2 - 1944 Huntington Hillsboro

VS Form 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 1944, at 3 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Vegetative Endocarditis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature: Robert Lee Graham M.D.
Medical Examiner.
Date signed Nov 1 1944

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22232

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G22232
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 mo.

2. USUAL RESIDENCE OF DECEASED:
(a) State MD. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Helen Derrick

3 (b) If veteran, name war No

3 (c) Social Security Account No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife No married

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-10-44

8. AGE: Years . | Months 5 | Days 21 | If less than one day ... hr. ... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Herman Derrick
13. Birthplace Tenn.

MOTHER
14. Maiden Name Lilly Matlock
15. Birthplace Va.

16 (a) Informant Mother Herman Derrick
(b) Address Ellicott City Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-4-44 (month) (day) (year)

(c) Cemetery or crematory Good Shepherd
Location Ellicott City Md.

18 (a) Funeral director H.C. Higinbotham
(b) Address Ellicott City Md

19 NOV 3 - 1944 (Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1 1944 at 9:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1944 to 11-1 1944, and that I last saw her alive on 11-1 1944.

Immediate cause of death	Resp. failure	
Due to	Pneumonia	
Due to	Severe Anemia	over
Other Conditions		

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration
over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at .M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas B. Elias M. D.
Address Univ. Hosp. Date signed 11-1-1944

G22233

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92D

G22233 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Give correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1014 Leadenhall
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 1014 Leadenhall St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Cassie Jane Hopper Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race C

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 26, 1857

8. AGE: Years 87 Months 2 Days 4 Hours Minutes — If less than one day

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Domestic

FATHER
12. Name Not Known
13. Birthplace

MOTHER
14. Maiden Name Not Known
15. Birthplace

16 (a) Informant Mary Thomas
(b) Address 1014 Leadenhall St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/ /44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park National
Location Balto City

18 (a) Funeral director Isaiah L. Brown & Son
(b) Address 108 W Montgomery St

19 (a) NOV 3 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30/44 19 , at 9:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26-1944, to 10-30-1944, and that I last saw h[illegible] alive on 10-30-1944

Immediate cause of death Endocarditis (Chronic) — Duration Unknown

Due to

Due to

Other Conditions Old age

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James C Carter M. D.
Address 1016 E. Lanvale St Date signed 11-2-44

WHEDBEE ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

G22234 — CERTIFICATE OF DEATH — 10 & G22234

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Bolton St., 14-1 Ward)

Length of residence in city or town where death occurred ..yrs. ..mos. ..ds. How long in U. S. If of foreign birth? ..yrs. ..mos. ..ds.

2. FULL NAME Mary Nicholas Wheedbee — If U. S. Veteran specify WAR.....

(a) Residence: No. 1515 Bolton St St., ... Ward.

(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Female	White	married

6a. If married, widowed, or divorced (or) WIFE of C. Maurice Wheedbee

6. DATE OF BIRTH (month, day, year) July 10, 1876

7. AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	68	3	23	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Home

10. Date deceased last worked at this occupation (month and year) October 1944

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (city or town) (State or country) Baltimore Co Maryland

FATHER

13. NAME Wilson Emery Nicholas

14. BIRTHPLACE (city or town) (State or country) Baltimore Co Maryland

MOTHER

15. MAIDEN NAME Augusta Moale

16. BIRTHPLACE (city or town) (State or country) Baltimore Md.

17. INFORMANT Mr C Maurice Wheedbee

(Address) 1515 Bolton St

18. BURIAL, CREMATION, OR REMOVAL

Place New Cathedral Date Nov 4 1944

19. UNDERTAKER Henry W Penfield & Son

(Address) 111 E Eutaw St

FILED NOV 3 - 1944 19.. Huntington Williams M.D.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) Nov 2, 1944

22. I HEREBY CERTIFY, That I attended deceased from July 1943 to Nov 2 1944

I last saw him alive on October 29, 1944 Death is said to have occurred on the date stated above, at 6 P m.

The principal cause of death and related causes of importance were as follows:

Rheumatic Heart Disease — Date of onset (approx.)

Aortic insufficiency, mitral stenosis + insufficiency + Auricular fibrillation — 10

Other contributory causes of importance: Lobar Pneumonia — Oct '44

Was an operation performed? no Date of.....

For what disease or injury?.....

Name of operation — Date of.....

What test confirmed diagnosis Clinical Was there an autopsy? No

22. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? — Date of injury.....

Where did injury occur? — (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.....

Manner of injury.....

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? no If so, specify.....

(Signed) Francis W. Fluck M. D.

(Address) 715 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Vol. 3

G22235

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22235 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 15 days.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2240 Brookfield Ave. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Dorothy Anita McCully

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/17/44

8. AGE: Years	Months	Days	If less than one day
-	-	15	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation --
11. Industry or business

FATHER
12. Name Anderson McCully
13. Birthplace Pennsa.

MOTHER
14. Maiden Name Blanche E. Schroll
15. Birthplace Iowa

16 (a) Informant Mrs. Elizabeth Schroll
(b) Address 2240 Brookfield Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/3/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 3 1944
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH NOV. 2 1944, at 1:15 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/17 1944, to 11/2 1944 and that I last saw her alive on 11/1 1944.

Immediate cause of death: Prematurity - 7½ mos. — Duration 15 Days.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strong M. D.
Address Md. General Hospital Date signed 11/2/44

Huntington Williams, M.D.

G22236

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G22236
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2541 Francis St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 13
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2541 Francis St.
(If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country

3 (a) FULL NAME Robert W. Frost

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife Margaret Frost
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Oct. 26-1875

8. AGE: Years	Months	Days	If less than one day
69		7	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Steamfitter
11. Industry or business Country Club

FATHER
12. Name Bertram Frost
13. Birthplace Virginia

MOTHER
14. Maiden Name Mary Jane Ellerson
15. Birthplace Virginia

16 (a) Informant Mrs. Margaret Frost
(b) Address 2541 Francis St

17 (a) Burial (b) Date thereof 11-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto. Md.

18 (a) Funeral director Wm J. Tickner & Sons
(b) Address Balto. Md.

19 (a) NOV 3 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1944 3 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 6 1944 to Nov. 2 1944, and that I last saw h[illegible] alive on Nov. 1 1944

Immediate cause of death

Chr. Myocarditis — Duration 1939

Due to

Due to Chr. Interstitial nephritis — 1939

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul Frost
Address 1663 Light St Date signed 11/2/44 M.D.

G22237

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22237 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2432 Keyworth
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-
(e) Length of stay in Baltimore (yrs., mos., or days) 40 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2432 Keyworth Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rebecca Pasroff

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Monroe Pasroff

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1883

8. AGE: Years 61 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation housewife

11. Industry or business

FATHER: 12. Name Aaron Prager
13. Birthplace Russia

MOTHER: 14. Maiden Name Ada -
15. Birthplace Russia

16 (a) Informant Monroe Pasroff
(b) Address 2432 Keyworth Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-3-44 (month) (day) (year)
(c) Cemetery or crematory Wildman Circle Cem.
Location Hebrew Mt. Carmel

18 (a) Funeral director Jacob Heinz Inc
(b) Address 1439 E. Balto. St.

NOV 3 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2-44 19... at 5 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 8 1944 to Nov 1 1944 and that I last saw M. alive on Nov 1 1944

Immediate cause of death Carcinoma of Transverse Colon: Metastasis — Duration 4 yrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 4 years ago

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Samuel Levitan M. D.

Address 1724 Eutaw Date signed 11/3/44

G22238

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

G22238 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2405 Lakeview Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 d
(e) Length of stay in Baltimore (yrs., mos., or days) 54

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 2405 Lakeview Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Max Reen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Freda

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Samuel Reen
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Wife
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-44 (month) (day) (year)
(c) Cemetery or crematory Chevra Kadisha Cem. Location Balto & Corkley Sts

18 (a) Funeral director Jack Lewis Lee
(b) Address 1439 E. Baltimore St

19 NOV 3 — 1944 Date filed by Registrar — Wm. Williams MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3rd 1944, at 8 30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 29 1944 to Nov 3 1944 and that I last saw h[illegible] alive on Nov 2 1944

Immediate cause of death: Coronary Thrombosis (Myocardial infarct) — Duration: 5 days

Due to Coronary Sclerosis Symp. & Signs — Duration: 8 years

Due to Generalized arteriosclerosis Chronic Bronchitis — Duration: 35 years 17 years

Other Conditions Diabetes mellitus

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Louis P. Hamburger M. D.
Address 1207 Eutaw Pl. Date signed Nov 3 44

G22239

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G22239

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5001 Litchfield Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days) 45

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5001 Litchfield Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Clorinda DiPietro,

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Joseph DiPietro
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Mar. 23, 1883

8. AGE: Years	Months	Days	If less than one day
61	7	8	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business at Home

FATHER
12. Name Ralph Varrate
13. Birthplace Italy

MOTHER
14. Maiden Name Anna Dimana
15. Birthplace Italy

16 (a) Informant Mr. Joseph DiPietro,
(b) Address 5001 Litchfield Ave.,

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem.
Location Baltimore City

18 (a) Funeral director C. Vernon Lemmon
(b) Address 4611 Park Heights Ave.

19 (a) NOV 3 - 1944 Huntington Williams M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1944, at 10.30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug 1943 to Nov 1 1944, and that I last saw her alive on Oct 31 1944.

Immediate cause of death: Coronary Thrombosis — Duration: Sudden

Due to: Arteriosclerosis

Due to: Coronary Arteries

Other Conditions: — Duration: 3 yrs

(Include pregnancy within 3 months)
Date of operation: None
Major findings of operation: Coronaries Calcified
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Huntington Williams M. D.
Address 1901 Eutaw Place. Date signed

G22240

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

50

Registered No. G22240

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1300 Caroline St
(c) Hospital or institution: St. Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Yrs 47
(e) Length of stay in Baltimore (yrs., mos., or days) 47

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1442 Light St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Helen M. Zarcone
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Paul A. Zarcone
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 7/31/97
8. AGE: Years 47 Months Days 14 If less than one day hr. min.
9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Wm Eisel
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Marie Schultz
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Marie Frasca
(b) Address 109 E. Fort Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4-1944 (month) (day) (year)
(c) Cemetery or crematory Baltimore National
Location Baltimore Md

18 (a) Funeral director Flynn & Flynning
(b) Address 1 N. Eight St.

NOV 3 - 1944 (Date rec'd by registrar) Huntington Williams MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1/44 19 , at 6:57 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1944 to 11/1 1944, and that I last saw h[illegible] alive on 10/31 1944

Immediate cause of death: Secondary to Carcinoma of Breast — Duration

Due to: Metastasis of Carcinoma over

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert P. McFadden M. D.
Address St Joseph's Hosp Date signed 11/1/44

G22241

AB-90082

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

46E

Registered No. G22241

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals

(d) Length of stay in hospital or inst. (yrs., mos., or days) 22days

(e) Length of stay in Baltimore (yrs., mos., or days) 27 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 928 Rutland Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Phillip Williams

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- (58?)

8. AGE: Years	Months	Days	If less than one day
58 ?	?	?	hr. min.

9. Birthplace N.C.a (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER — 12. Name Woodley Williams

13. Birthplace N.C.

MOTHER — 14. Maiden Name Audrey Perry

15. Birthplace N.C.

16 (a) Informant Baltimore City Hospitals (Record)

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1944 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary

Location

18 (a) Funeral director A. Halsted

(b) Address 918 Druid Hill Ave.

(a) NOV 3 - 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-26- 1944 at 8.45PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-4 1944, to 10-26- 1944, and that I last saw h im alive on 10-26- 1944.

Immediate cause of death	Duration
Pneumonia ?	
Due to Post operative Ca of Sigmoid & Generalized	
Due to metastases	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation 10-14-44

Major findings of operation Ca of Sigmoid & generalized metastases

of autopsy None

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

Signature H Leitch M. D.

Address Fort Alg Hosp Date signed 11-1-44

G22242

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 167

G22242 Registered No.

Every item of information should be carefully supplied. Do not write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital 1514
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 606 Calleth Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Alessia Johnson
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	Negro	Married

6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1919

8. AGE: Years	Months	Days	If less than one day
25			hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Guiney Jackson
13. Birthplace Kentucky

MOTHER
14. Maiden Name Mary Marshall
15. Birthplace Virginia

16 (a) Informant Margaret Boston
(b) Address 2218 Etting St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 3 1944 (month) (day) (year)
(c) Cemetery or crematory Mount Calvary
Location
18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.
19 NOV 2 - 1944 (Date rec'd by registrar) at Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-29- 1944, at 7.50 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Stab wound of Heart
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-29- at 7.45 P. M.
(b) Where did injury occur? Street - in front of 1856 Penna. Ave
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Sharp instrument
23. Signature Howard J. Wooden M.D. Medical Examiner.
Date signed 10-30-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. correct age is especially important. Physicians: please write

V8 151

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22243

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

18a

Registered No. G22243

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution:
U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since 8/9/44
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1025 Sarahann Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME JOHN THOMAS GOODS

3 (b) If veteran, name war --

3 (c) Social Security Account No. 216-12-9024

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Homelzelle Washington
6 (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) 12/18/1884

8. AGE: Years	Months	Days	If less than one day
59	10	14	____ hr. ____ min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Merchant Marine

FATHER
12. Name James Goods
13. Birthplace ? Va.

MOTHER
14. Maiden Name Elizabeth Rowson
15. Birthplace Northumberland Co., Va.

16 (a) Informant Records, U.S. Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location

18 (a) Funeral director Mrs Katie R. Williamson
(b) Address 32 [illegible]

NOV 3 1944 (b) Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION A.

20. DATE OF DEATH November 1, 1944, at 1:02 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 9, 1944 to Nov. 1, 1944, and that I last saw him alive on Nov. 1, 1944

Immediate cause of death Thrombosis of pulmonary artery with resulting infarction in lower lobe of right lung. Marked dilatation of the right side of the heart with marked myocardial degeneration.

Duration: Terminal

Other Conditions Healing fracture rt. tibia, fibula. X-ray
(Include pregnancy within 3 months of death)

Date of operation 8/9/44

Major findings of operations:

of autopsy: As above.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide Accident ?
(b) Date of occurrence 8-9-44 at ? M
(c) Where did injury occur? Chesapeake Bay (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? On ship (Specify type of place) While at work? yes
(e) Means of injury Slipped and fell to deck

23. Signature Benjamin Jones M.D.
M. D.
Address Baltimore, Md. Date signed 11/1/44

MS-54707

For S.R.L. Graham, M.D. Howard S. Malleis, M.D.

G22244

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G22244

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Give the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2519 Guilford Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12-9
(e) Length of stay in Baltimore (yrs., mos., or days) 82 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County -------
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2519 Guilford Avenue (If rural give location)
(e) Citizen of foreign country? ------- (Yes or No)
If yes, name country -------

3 (a) FULL NAME Anne T. Groeninger

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife John J. Groeninger
6 (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.) Nov. 17, 1861

8. AGE: Years	Months	Days	If less than one day
82	11	14	--hr. --min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business -----

FATHER
12. Name Luke Jennings
13. Birthplace Ireland

MOTHER
14. Maiden Name -------
15. Birthplace Ireland

16 (a) Informant Andrew J. Groeninger
(b) Address 2500 Queen Anne Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) (b) Huntington Williams M.D. Registrar

NOV 3 - 1944

V8 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 - 1944, at 11.58 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to Nov 1 1944 and that I last saw alive on Nov 1 19 44

Immediate cause of death: Pulmonary Cerebral Hemorrhage — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. Ephraim M.D.
Address 4436 Eastern Ave Date signed 11-3-44

G22245

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 D ✓

G22245 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1721 N. Calvert st.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1721 N. Calvert St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) **FULL NAME** Emma Rebecca Hellen

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James W. Hellen
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 7th 1867

8. AGE: Years 77 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Home

11. Industry or business

FATHER
12. Name John T. Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Virginia V. Denton
15. Birthplace Md.

16 (a) Informant James W. Hellen
(b) Address 1721 N. Calvert St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/44 (month) (day) (year)
(c) Cemetery or ~~crematory~~ St. Paul's
Location Calvert Co. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St Paul St

19 (a) NOV 3 1944 (Date received by registrar) Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2nd 1944 at 12 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 2 1944 and that I last saw h[illegible] alive on Nov 2 1944

	Duration
I. Disease causing death (A) Cerebral Hemorrhage	
Due to (B) Arteriosclerosis	?
Due to (C) Myocarditis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M.
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas J. Stevenson M.D.
Address 200 E Fayette St Date signed 11/3/44

G22246

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55E

G22246 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2572 W. Fairmount Ave.
(c) Hospital or institution

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2572 W. Fairmount Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Catherine E. Ruppricht

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~ Widowed

6 (b) Name of husband Henry F. Ruppricht 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 25th 1847

8. AGE: Years 97 | Months 9 | Days 7 | If less than one day hr. min.

9. Birthplace Germany (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business Self

FATHER 12. Name Unknown Steinbach
13. Birthplace Germany

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Miss Annie Wedemeyer
(b) Address 2572 Fairmount Ave

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/4/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Balto. Md.

18 (a) Funeral director Williams Cook Inc
(b) Address 1217 St. Paul St

19 (a) (Date received) NOV 3 1944 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2nd 1944, at 1 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1944 to Nov 2 1944 and that I last saw h[illegible] alive on Nov 2 1944.

Immediate cause of death Insufficiency of Heart — Duration 6 mos.

Due to

Due to

Other Conditions Thyrocardiac — 3 mos.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Daniel L. Hranda M. D.
Address 1945 W. Balto Date signed 11/3/44

VS 190

C22247

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. C22247

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1511 N Dell Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26-4
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1511 N Dell Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Caroline Fredericka Schlatter

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Theo A Schlatter
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Oct 25 1883

8. AGE: Years 61 | Months — | Days 6 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Chas Patschke
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie Schomberg
15. Birthplace Baltimore

16 (a) Informant Mrs Bernadine Betz
(b) Address 1509 N Dell Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4 (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Rural

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-8 Orleans

NOV 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31 1944, at 2 15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 22/44, to Oct 31-44, and that I last saw h.er alive on Oct 30/44

	Duration
Immediate cause of death Coronary Occlusion	1 hour
Due to Valvular Sclerosis	1 mo
Due to	
Other Conditions	

(Including pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature H. W. Ferguson M. D.
Address 1710 E 33rd St Date signed 11-4-44

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G22248

JL - 90479

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1-31-a

Registered No. G22248

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4940 Eastern Ave.

(c) Hospital or institution: Baltimore City Hospitals 26

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County

(c) City or town Baltimore 8

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3736 E. Lombard St.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Clarence Smith

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Loretta Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 10 th 1880

8. AGE: Years 64 | Months 0o | Days 24 22 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Joseph Smith

13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Little

15. Birthplace Maryland

16 (a) Informant B. C. H. Records

(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4th (month) (day) (year)

(c) Cemetery or crematory Baltimore Cem. City

Location

18 (a) Funeral director Ulrich Funeral Home

(b) Address 2004-8 Orleans St

(Date rec'd by registrar) NOV 3 - 1944 Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/2/44 19 at 9 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1-44 19 to 11/2/44 19, and that I last saw him alive on 11/2/44

Immediate cause of death Uremia — Duration 5-6 d?

Due to Renal failure (Chr. glomerulonephritis?) and Arteriosclerotic heart disease & failure

Other Conditions Bronchopneumonia, R.L.L. ; pleural effusion; heart

(Include pregnancy within months of death)

Diseases specific

Major findings of operation:

of autopsy: none

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature C. A. Berry Jr. M.D.

Address City Hosp. Date signed 11/3/44

G22249

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13a

G22249 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 602 N Broadway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 5
(e) Length of stay in Baltimore (yrs., mos., or days) Life time

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 602 N Broadway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Gustav J Ecke

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 2/9/187

8. AGE: Years	Months	Days	If less than one day
73	8	1 22	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Store Manager
11. Industry or business retired

FATHER
12. Name Charles Ecke
13. Birthplace Baltimore Germany

MOTHER
14. Maiden Name Margaret Strauss
15. Birthplace Germany

16 (a) Informant Henry Ecke
(b) Address 1921 E 02Nd St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4/44 (month) (day) (year)
(c) Cemetery or crematory Lorraine Cem
Location Windsor Mill Road

18 (a) Funeral director Wm J Finn Home
(b) Address 2008 Orleans St

NOV 3 - 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1944, at 5-50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 1-5 1943 to 11-1- 1944, and that I last saw h. alive on 10-31 1944

Immediate cause of death	Duration
Chronic Interstitial Nephritis	4 Yrs
Arterial Hypertension	
Uremic Insufficiency	
Due to	
Other Conditions Cardiac Dilatation	1 Day

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State).
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Albert Eisenberg M. D.
Address 2025 E North Ave Date signed 11-2-44

G22250 BALTIMORE CITY HEALTH DEPARTMENT G22250

CERTIFICATE OF DEATH 1460 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts.
(c) Hospital or institution: University Hosp of Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day.
(e) Length of stay in Baltimore (yrs., mos., or days) 0
Lived in Cooksville for life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Cooksville Md.
(If outside city or town limits, write RURAL and give town)
(d) Street No. —
(If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Julia Mary (Sands) Fossett ♀ 12524

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Nathan John Fossett
6 (c) If alive, give age 35 years

7. Birth date of deceased (mo., day, yr.) March 19, 1911

8. AGE: Years	Months	Days	If less than one day
33	7	14	hr. min.

9. Birthplace Cooksville, Howard Co. Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name Joseph Allen Sands
13. Birthplace Cooksville, Maryland

MOTHER
14. Maiden Name Julia May Sadds
15. Birthplace Cooksville Maryland

16 (a) Informant Alberta Parker (Sister)
(b) Address 1014 Madison Ave 3rd Floor front

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6. 1944 (month) (day) (year)
(c) Cemetery or crematory Bush Park
Location Cooksville Howard Co.

18 (a) Funeral director H. M. Snyder
(b) Address Mt. Airy

NOV 3 - 1944 (b) Huntington Williams M.D.
(Date received by local registrar) (Signature of local registrar)

VS 160

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 3 - 1944 at 7.30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11 - 2 1944 to 11 - 3 1944, and that I last saw h[illegible] alive on 11 - 3 1944.

Immediate cause of death	Duration
Partial Placenta Previa	
Due to Rupture of placenta Laparo-Hysterectomy	
Due to Hemorrhage	
Other Conditions Shock	

(Include pregnancy within 3 months of death)

Date of operation 11-3-44
Major findings of operation: Partial placenta previa
of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature James S. Shortle M. D.
Address Univ. Hosp. Date signed 11/3/44

G22251

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

167

G22251
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 126 N. Aisquith Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Graham

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1914

8. AGE: Years 30 | Months | Days | If less than one day hr. min.

9. Birthplace (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

NOV 3 - 1944 (Date rec'd by registrar) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-20-1944, at 12-35 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH: Fractured skull, Subdural Hemorrhage

Due to

Other Conditions Frontal lobe hemorrhage

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 10-14-44 at 11.30A M.
(b) Where did injury occur Lexington St, Bet. Wiegand & Central
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Blunt force - sharp instrument

23. Signature Thomas J. Mullen M.D.
Medical Examiner.
Date signed 10-21-44

2275

G22252

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

927

Registered No. G22252

70 #75856

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 25
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2yrs. 2mos. 22 days.
(e) Length of stay in Baltimore (yrs., mos., or days) 54 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4716 Curtis Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Frane

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1873

8. AGE: Years 71 | Months 5 | Days 9 | If less than one day hr. min.

9. Birthplace Czechoslovakia
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Andy Frane
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Katie ?
15. Birthplace Czechoslovakia

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 3 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 3 - 1944 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 27, 1944, at 1402 M

21. I certify that death occurred on the date above stated; that I attended deceased from 8/5 1942 to 10/27 1944, and that I last saw h/m alive on 10/27 1944.

Immediate cause of death pulmonary embolism

Duration 10 min.?

Due to

Due to

Other Conditions arteriosclerotic heart disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. C. Pareyo Jr.
Address City Hosp. Date signed 11/3/44 M. D.

VS 150

2276

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22253

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55e

Registered No. G22253

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Kent Co.
(c) City or town Chestertown
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Robert Trout

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Lucy Lotta

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8-5-75

8. AGE: Years 69 | Months 2 | Days 27 | If less than one day hr. min

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Canning factory
11. Industry or business

FATHER
12. Name John G. Trout
13. Birthplace Va

MOTHER
14. Maiden Name Mary Ann Kenner
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 4 1944 (month) (day) (year)

(c) Cemetery or crematory Location Earleigh Hts. Johnsburg Earlville

18 (a) Funeral director Sheppard & Welbourn
(b) Address Millington Md.

19 NOV 3 - 1944 (b) Huntington Williams M.D.
(Date received by Registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov- 2 1944 at 10 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9 1944 to Nov-2 1944 and that I last saw him alive on Nov-2 1944.

	Duration
Immediate cause of death pulmonary embolism	
Due to phlebo-thrombosis of veins of leg, rt.	? 12d
Due to	
Other Conditions Melanosarcoma	6 yrs

(Include pregnancy within 3 months of death)
Date of operation Oct 23, 1944
Major findings of operations: Biopsy
of autopsy: Pulmonary embolism, Melanosarcoma

PHYSICIAN
Underline the cause to which death should be charged statis-

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
(f) Signature Howard Watts M. D.
Address Johns Hopkins Hospital Date signed 11-3-44

G22254

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G22254

File No. 41495

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 -10- 4 26-12
(e) Length of stay in Baltimore (yrs., mos., or days) 29 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. No Home (Baltimore City Hosp.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Sarah Downs

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 1st, 1860

8. AGE: Years 84 | Months 4 | Days 25 | If less than one day hr. min.

9. Birthplace Eastern Shore , Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Irving Downs
13. Birthplace Calvert County, Maryland

MOTHER
14. Maiden Name Louisa Dairy
15. Birthplace Calvert County, Maryland

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/2/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Light St

19 Date rec'd NOV 3 1944 Huntington Williams Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 26. 1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 - 1944, to 10-26 1944, and that I last saw h[illegible] alive on 10-26 1944

Immediate cause of death Arteriosclerotic heart disease. Duration 10 yrs (?)

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. E. Cleary Jr. M.D.
Address City Hosp. Date signed 10/30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22255

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22255

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 234 E Barney St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 234 E Barney St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nicholas A Finke

3 (b) If veteran, name war No | 3 (c) Social Security Account No. None

4. Sex male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. married.

6 (b) Name of husband or wife Maud M. Finke
6 (c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) 5/1/1866

8. AGE: Years 78 | Months 6 | Days 30 | If less than one day hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Funeral Director

11. Industry or business

FATHER
12. Name Adam Finke
13. Birthplace Germany

MOTHER
14. Maiden Name Mary Peters
15. Birthplace Germany

16 (a) Informant Maud. M. Finke
(b) Address 234 E. Barney St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 4-1944 (month) (day) (year)
(c) Cemetery or crematory New Catholic
Location Frederick Rd.

18 (a) Funeral director Ellsworth Cremont
(b) Address 3911 Liberty Heights Ave

NOV 3 1944 (Date received by Local Registrar) (b) Huntington Williams M.D. Registrar

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 28 1944 to Oct 31 1944, and that I last saw him alive on Oct 31 1944.

Immediate cause of death | Duration
Cerebral Hemorrhage | 3 days
Due to
Due to Arteriosclerosis | Indefinite
Other Conditions

(Indicate pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature H. E. Campbell M. D.
Address 1644 Hanover St Date signed 11/1/44

Dr. Alessi

3k. Harford Rd.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 13 1a

Registered No. G22256

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4700 Harford Road
(c) Hospital or institution:
Snyder's Convelscing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2626 Wendover Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Minnie Sacks

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife Bernard Sacks
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4, 1867

8. AGE: Years	Months	Days	If less than one day
77	3	27	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER
12. Name Anton Rhein
13. Birthplace Germany

MOTHER
14. Maiden Name Margaret Shall
15. Birthplace Germany

16 (a) Informant Mrs. Agnes Kraft
(b) Address 2626 Wendover Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/44 (month) (day) (year)
(c) Cemetery or crematory New Cathdral
Location Baltimore, Maryland

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Road

19 (a) Date received NOV 3 1944 (b) Registrar Huntington Williams M.D.

VS 1se

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1st 1944, at 5:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from March 18 1941, to Nov 1, 1944, and that I last saw h alive on Nov 1, 1944

Immediate cause of death	Duration
Arteriosclerotic cardio-vascular renal disease	3 yrs
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Edison M. D.
Address 6217 Harford Rd Date signed 11/3/44

S222517

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. S22257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 13
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 days
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore 6
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Roland Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ELIZABETH D. LINTON

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Benjamin J. Linton
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1896

8. AGE: Years	Months	Days	If less than one day
48	9	30	hr. min.

9. Birthplace New Jersey (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Dehn
13. Birthplace New Jersey

MOTHER
14. Maiden Name EMMA Anna Haefner
15. Birthplace New Jersey

16 (a) Informant Mrs. Robt. O. Boas
(b) Address 3506 Roland Ave. City

17 (a) Burial (b) Date thereof Nov. 4-1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mendvoridge Memorial Park
Location Howard Co. Maryland

18 (a) Funeral director Burgee Funeral Home
(b) Address 3231 Gralla Road

19 NOV 3 1944 (b) Huntington Williams M.D.
(Signature of Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1 1944, at 2 A M

21. I certify that death occurred on the date above stated; that I attended deceased from October 1944, to Nov. 1 1944, and that I last saw her alive on Oct. 31 1944.

Immediate cause of death	Duration
Coronary occlusion	
Due to Cerebrovascular accident	2 days
Due to Arteriosclerosis	
Other Conditions Diabetes	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Hampton Jr. M. D.
Address 334 E. University Pkwy Date signed 11/1/44

G22258

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

64

V G22258 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 5-5-28 Rurak Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 27
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 5-314 W inner Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard Howard Roe

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 7/29/44

8. AGE: Years | Months 3 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER 12. Name Kenneth V. Roe

13. Birthplace Montreal Canada

MOTHER 14. Maiden Name Mary L. Evans

15. Birthplace Baltimore, Md.

16 (a) Informant Kenneth V. Roe

(b) Address 5314 Winner Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge

Location Pikesville, Md.

18 (a) Funeral director Lorman Byers

(b) Address 5005 Park Heights Ave

NOV 3 - 1944 (Date rec'd.) (b) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2-1944, at 12 36 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH

Status Thymicus

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury at M.

(b) Where did injury occur?

(c) Did injury occur at home, on farm, industrial place, in public place? While at work?

(d) Means of injury

23. Signature Howard J. Madden M.D. (Medical Examiner.)

Date signed 11-2-44

G22259

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 50

Registered No. G22259

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Howard
(c) City or town Ellicott City
(If outside city or town limits, write RURAL and give town)
(d) Street No. Main St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Nellie Scott

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race C | 6 (a) Single, married, widowed, or divorced. married

6 (b) Name of husband or wife Rufus L. Scott
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 8, 1914

8. AGE: Years 30 | Months 6 | Days 24 | If less than one day hr. min.

9. Birthplace Md. (Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name Marcellus Hammond
13. Birthplace Md

MOTHER 14. Maiden Name Rachael Fuller
15. Birthplace Md

16 (a) Informant Mrs. Marcellus Hammond
(b) Address Ellicott City, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 5, 1944 (month) (day) (year)

(c) Cemetery or crematory Fuller Family
Location Pine Orchard Md.

18 (a) Funeral director Easton Sons
(b) Address Ellicott City, Md.

19 NOV 3 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 1944, at 10 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/26 1944 to 11/1 1944. and that I last saw her alive on 11/1 1944

Immediate cause of death	Duration
Pulmonary edema	
Due to Duct cell CA of Breast with	
Due to multiple metastasis	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: None
of autopsy: Same

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Univ. Hosp. Date signed 11/3/44

VS 180

G22260

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1st & Redwood & Green
(c) Hospital or institution: Union. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 55 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A. A. County
(c) City or town Pasadena
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Alton Yockel

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Flora E. Yockel
6 (c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) May 28, 1905

8. AGE: Years	Months	Days	If less than one day
39	5	5	hr. min.

9. Birthplace Pasadena, Md. (Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business

FATHER
12. Name George Yockel
13. Birthplace A. A. County, Md.

MOTHER
14. Maiden Name Ella Johnson
15. Birthplace A. A. County, Md.

16 (a) Informant Mrs. Flora E. Yockel
(b) Address Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Cemetery
Location Glen Burnie, Md.

18 (a) Funeral director Miller Donovan
(b) Address 1604 W. Baltimore St.

19 NOV 3 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

Alton J. Yockel

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1944 at 6:30 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 23 1944, to Nov. 3 1944, and that I last saw h.im alive on 11/3 1944

Immediate cause of death Respiratory failure — Duration

Due to Subdiaphragmatic Hem.

Due to Pneumonia, Lobar

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature R. Clemmenger

Address Union Hosp Date signed 11/3/44

G22261

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 181

G22261 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Church Home Infirmary
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 6528 St. Helena Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas John Hendersons Jr.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 5, 1939

8. AGE: Years 5 | Months 4 | Days 26 | If less than one day hr. min.

9. Birthplace Dundalk, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Thomas John Henderson
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Elvina M. Quesnal
15. Birthplace Baltimore County, Md.

16 (a) Informant Mrs. Elvina M. Henderson
(b) Address 6528 St. Helena Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cemetery
Location Baltimore, Md.

18 (a) Funeral Director Willis Lawrence
(b) Address 4510 Liberty Heights Ave.

NOV 3 - 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-1- 1944, at 8:30 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Toxemia

Due to 2-3rd degree burns

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following: 26/6

(a) Date of injury 10-31-44 2:15 P.M.
(b) Where did injury occur? Backyard of home
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury: Standing around bon fire - clothes caught fire

23. Signature Henry J. Steiner M.D. Medical Examiner.

Date signed 11-2-44

G22262

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No. G22262

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2516 Madeira Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2516 Madeira Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William C. Hackett

3 (b) If veteran, name war | 3 (c) Social Security Account No. #

4. Sex Male | 5. Color or race Col. | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Ida H.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 4, 1868

8. AGE: Years 75 | Months 11 | Days 28 | If less than one day hr. min.

9. Birthplace Frederick Co. Md. (Town, county, and state)

10. Usual Occupation Carpenter

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Mrs. Meredith P. Henderson
(b) Address 2516 Madeira Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory Rocky Hill
Location Clarksburg, Md.

18 (a) Funeral director Mrs. Lawrence V. Holland
(b) Address 1631 Druid Hill Ave.

19 (a) Filed NOV 9 1944 (b) Registrar Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2nd 1944 at 4 A M

21. I certify that death occurred on the date above stated; that attended deceased from Oct 25th 1944 to Nov 2nd 1944 and that I last saw him alive on Nov 2nd 1944.

Immediate cause of death	Duration
Myocarditis	6 days
Due to Hemi-Plegia	1 week
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: No

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. F. Guyon M.D.
Address 5 E. Sterling Place Date signed 11/8/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

VS 150

G22263

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1310

Registered No. G22263

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 628 N. Lafayette Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 or 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 628 N. Lafayette Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ella C. Hagen

3 (b) If veteran, name war

3 (c) Social Security Account No. +

4. Sex Female | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles C.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1865

8. AGE: Years 79 | Months 9 | Days 26 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Josiah Bowen
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Maria Agnebee
15. Birthplace Baltimore, Md.

16 (a) Informant Charles C. Hagen
(b) Address 628 N. Lafayette Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Lucy A. Stull
(b) Address 1601 Druid Hill Ave. Huntington Williams, M.D.

19 (a) NOV 3 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 31 – 1944, at 5 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 1 – 1944, to Oct. 31 1944, and that I last saw her alive on Oct. 31 – 1944.

Immediate cause of death	Duration
Chr. interstitial nephritis	[illegible]
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas. J. Keller M. D.
Address 222 W. Monument Date signed 11-3-44

Keller

VS 150

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

022264

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22264

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1745 N. Carey St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give name)
(d) Street No. 1745 N. Carey St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William G. Washington

3 (b) If veteran, name war

3 (c) Social Security Account No. H

4. Sex Mal

5. Color or race Col.

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Janet

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 6, 1918

8. AGE: Years 25 | Months 11 | Days 25 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation Chauffeur

11. Industry or business

FATHER
12. Name General G. Washington
13. Birthplace Va

MOTHER
14. Maiden Name Mattie Smith
15. Birthplace Va

16 (a) Informant General G. Washington
(b) Address 1745 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 7 (day) 44 (year)
(c) Cemetery or crematory St. Thomas
Location Baltimore Co. Md.

18 (a) Funeral director Thos. Geo. H. Hylton
(b) Address 1651 Druid Hill Ave.

19 NOV 3 – 1944 (Date rec'd by Registrar) (Signature) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 (month) 4 (day) 44 (year) P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/44 to 11/4/44 and that I last saw h[illegible] alive on 11/4/44

Immediate cause of death
Coronary Occlusion
Pulmonary
Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. G. Williams M. D.
Address 1745 N. Carey St. Date signed 11/7/44

VS 150

G22265

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22265 Registered No. 170 C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Provident Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 11
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 Madison Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Carl S. Wise

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	Colored	Seperated

6 (b) Name of husband or wife Victoria Wise

6 (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) January 30 1896

8. AGE: Years	Months	Days	If less than one day
48	9	1	hr. min.

9. Birthplace Va. (Town, county, and state)

10. Usual Occupation Janitor

11. Industry or business

FATHER 12. Name Elbert Wise
13. Birthplace Va.

MOTHER 14. Maiden Name Fannie Spates
15. Birthplace Va.

16 (a) Informant Victoria Wise
(b) Address 1019 Madison Ave

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Nov 3, 1944 (month) (day) (year)

(c) Cemetery or crematory
Location Cape Charles Va.

18 (a) Funeral director Robert K. Conway
Address 1914 Carrollton Ave.

19 (a) NOV 4 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 1, 1944, at 3 30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed chest
Fracture of pelvis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: 16/3 2 30 A.M.

(a) Date of injury Nov 1st 1944
(b) Where did injury occur? In front of 903 N. Vincent St
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Struck by Vehicle ?

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Nov 1 1944

VS 151

G22266

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22266

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Where no correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 546 Wilson St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 546 Wilson St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Cora E. Franklin

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1889

8. AGE: Years 55 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER — 12. Name Robert Gross
13. Birthplace Md.

MOTHER — 14. Maiden Name Harriett Young
15. Birthplace Md.

16 (a) Informant Mrs. Marie Thomas
(b) Address 1228 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frances A. Hemsley
(b) Address 578 W. Biddle St.

NOV 4 - 1944 (Date rec'd by registrar) (Signature) Huntington Williams, M.D.

MEDICAL CERTIFICATION A

20. DATE OF DEATH 11-3-44 19 , at 2:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3-11- 1943, to 11-3- 1944 and that I last saw her alive on 10-31- 1944

Immediate cause of death	Duration
Cerebral hemorrhage	
Due to Cardio-vascular disease	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C.R. Campbell M. D.
Address 718 Dolphin St. Date signed 11-3-44

VR 150

G22267

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1308 W. Lanvale St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1308 W. Lanvale St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Willaim H. Gantt

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Widower

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 1871

8. AGE: Years	Months	Days	If less than one day
72	11		hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)
10. Usual Occupation Laborer
11. Industry or business

FATHER
12. Name Albert Gantt
13. Birthplace Md.

MOTHER
14. Maiden Name Elither Johnson
15. Birthplace Md.

16 (a) Informant Mr. Wm. R. Gantt
(b) Address 1308 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn Cem.
Location Baltimore, Md.

18 (a) Funeral director Mrs. Frnaces A. Hemsley
(b) Address 578 W. Biddle St.

NOV 4 1944 (b) Huntington Williams, M.D. Registrar
(Date received by Registrar)

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH 11-3-44 19 , at 9:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/24/44 to 11/3/44 and that I last saw him alive on 11/3/44

Immediate cause of death: Cerebral Hemorrhage

Due to Embolism arteria Fem. left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 10 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hiram Ellis M. D.
Address East Mob Date signed 11/4/44

G22268

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

63c

Registered No. G22268

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) —

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTIMORE (If outside city or town limits, write RURAL and give town)
(d) Street No. 3229 ST. Paul ST. (If rural give location)
(e) Citizen of foreign country? No (Yes or No) If yes, name country

3 (a) FULL NAME MRS. ALICE G. WEHLAND (Alice Genevieve Wehland)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: none

4. Sex: F
5. Color or race: W
6 (a) Single, married, widowed, or divorced: M

6 (b) Name of husband or wife WM. D. WEHLAND
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3/12/1886

8. AGE: Years 58 | Months 7 | Days 21 | If less than one day hr. min.

9. Birthplace MASSACHUSETTS (Town, county, and state)

10. Usual Occupation HOUSEWIFE

11. Industry or business —

FATHER
12. Name ? King
13. Birthplace Mass.

MOTHER
14. Maiden Name Unknown
15. Birthplace Mass.

16 (a) Informant Mr. Wm. D. Wehland
(b) Address 3229 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date received by Registrar) NOV 4 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1944 at 7:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 11 1944 to Nov. 3 1944, and that I last saw HER alive on Nov. 2 1944.

	Duration
Immediate cause of death ANGINA PECTORIS & SYS HYPERTENSION	UNKNOWN
Due to MYXEDEMA	"
Due to CARDIAC INSUFFICIENCY	"
Other Conditions ARTERIOSCLEROSIS	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M.C. Robertson M. D.
Address St. Joseph's Hospital Date signed 11-3-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22269

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22269 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1116 S. Potomac St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 1116 S. Potomac St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME KATE R. HELM

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife James E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 21, 1871

8. AGE: Years	Months	Days	If less than one day
73	0	11	hr. min.

9. Birthplace Balto., Md. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name John G. Ernst
13. Birthplace Germany

MOTHER
14. Maiden Name Johanna List
15. Birthplace Pa.

16 (a) Informant Mr. James E. Helm
(b) Address 1116 S. Potomac St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn Cem.
Location Woodlawn, Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) Hunting Williams, M.D. Registrar
(Date rec'd by registrar)

NOV 4 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1944, at 7:07 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1942 to Nov 2 1944 and that I last saw her alive on Nov 2 1944

Immediate cause of death Generalized Arteriosclerosis
Due to Coronary Thrombosis
Due to Coronary occlusion
Other Conditions None

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation: None
of autopsy: None

Duration
10-15-42
6-1-44
11-2-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence None at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature E. Schumunk M. D.
Address 542 E. 41st St. Date signed 11-3-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22270

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

Registered No. G22270

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3810 W. Garrison Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Pa. (b) County
(c) City or town Library
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK W. DORSEY

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Mary E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
about 77 yrs.			hr. min.

9. Birthplace Reisterstown, Md.
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name John Dorsey
13. Birthplace Md.

MOTHER
14. Maiden Name Mary
15. Birthplace

16 (a) Informant Mrs. Estelle Proctor
(b) Address 3810 W. Garrison

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory Ward's Chapel
Location

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 4 - 1944 (Date rec'd by registrar) (b)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3, 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 1941 to Nov 3 1944, and that I last saw h alive on Nov 1 1944

Immediate cause of death: Endocarditis. — Duration: 2 yrs

Due to

Due to

Other Conditions Arterio Sclerosis — 10 yrs.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature F. L. De Barbieri M. D.
Address 4723 Park Heights Ave Date signed 11/3/44

VS 150

G22271

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G22271
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1507 Poplar Grove St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16-7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1507 Poplar Grove St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY A. RIGDON

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Ralph H. Rigdon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/22/1868

8. AGE: Years	Months	Days	If less than one day
75	10	9	hr. min.

9. Birthplace Level, Harford Co., Md. (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Ronfield Gorrell
13. Birthplace Harford Co., Md.

MOTHER
14. Maiden Name Sarah Small
15. Birthplace Harpers Ferry, W. Va.

16 (a) Informant Mr. Normal L. Rigdon
(b) Address 1507 Poplar Grove St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/4/44 (month) (day) (year)
(c) Cemetery or crematory Rock Run
Location Harford Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 4 - 1944 (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Nov. 1, 1944 at 11:30M

21. I certify that death occurred on the date above stated; that I attended deceased from December 5 1941 to November 1 1944. and that I last saw h[er] alive on November 1 1944.

Immediate cause of death	Duration
Coronary Thrombosis	4 hrs.
Due to Hypertension & Arteriosclerosis	7 yrs.
Due to	
Other Conditions Hemiplegia	2 years

(Include pregnancy within 3 months of death)

Date of operation None
Major findings of operation:
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jean Aelmen M. D.
Address 1720 Poplar Grove St Date signed 11-3-44

G22272

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 163H

G22272 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2537 Madeson Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2537 Madeson Avenue 3rd. floor (Descriptive location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Norman Douglas

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 219-22-4007
4. Sex: Male
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Agnes W. Douglas
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): August 12, 1902
8. AGE: Years 42 | Months 2 | Days 21 | If less than one day: hr. min.
9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Messinger
11. Industry or business: U.S. Custom House

FATHER
12. Name: George Douglas
13. Birthplace: Md.

MOTHER
14. Maiden Name: Annie Douglas
15. Birthplace: Md

16 (a) Informant: Agnes W. Douglas
(b) Address: 2537 Madison Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-44 (month) (day) (year)
(c) Cemetery or crematory: Balto. National
Location: Baltimore, Md.

18 (a) Funeral director: Charles R. Law
(b) Address: 802 Madison Ave.

19 (a) (Date received by Registrar) NOV 4 1944 Huntington Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1944, at 5:45 P. M

21. I certify that I took charge of the remains described above, held an inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☒, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Carbon monoxide poisoning
suicide.

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-2-44 at 5:15 P. M.
(b) Where did injury occur? 2537 Madison Avenue
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury: Kitchen gas stove

23. Signature: W. F. Wallenmeyer M.D. Medical Examiner.
Date signed: November 3, 1944

G22273

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22273
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1715 Madison Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1715 Madison Ave
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Infant Jackson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex M | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
		1	3 hr. 22 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name John Jackson
13. Birthplace Md.

MOTHER
14. Maiden Name Anita Snowden
15. Birthplace Md.

16 (a) Informant John Jackson
(b) Address 1215 Madison Ave.

17 (a) Burial (b) Date thereof 11-4-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore, Md.

18 (a) Funeral director Charles R. Law
(b) Address 802 Madison Ave.

19 (a) (b)
(Date rec'd by registrar) Registrar

VS: NOV 4 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1, 1944, at 6:40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1944 to Nov 1 1944, and that I last saw h[illegible] alive on Nov 1 1944.

Immediate cause of death: Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M Eulger M. D.
Address 803 N Fremont Ave. Date signed Nov 3

G22274

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 126

G22274 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green
(c) Hospital or institution:
Univ. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Halethorpe Landsdowne
(If outside city or town limits, write RURAL and give town)
(d) Street No. 241 Secondan
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Hoffman - Offelman

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-07-9548

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	white	married

6 (b) Name of husband or wife Annie E. (Merson)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 25, 1884

8. AGE: Years	Months	Days	If less than one day
59	8	7	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Crane operator
11. Industry or business Koppel Co.

FATHER
12. Name George Offelman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Annie Hauck
15. Birthplace Baltimore

16 (a) Informant Mrs Annie E. Hoffman
(b) Address 241 Second ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11.6.44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location B901 Frederick Rd

18 (a) Funeral director Harry A Witzke
(b) Address 4101 Edmondson Ave

NOV 4 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1944, at 1:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 31 1944, to Nov. 2 1944, and that I last saw h.. alive on Nov. 1 1944.

Immediate cause of death Tuberculosis due to pulmonary TBC + gangrene of both lungs or Hemiplegia

	Duration
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mabel E. Drake M. D.
Address Univ. Hospital Date signed 11-2-44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22275

JO #90224

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 95B

G22275
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals 27-1
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4017 Biddison Lane, Belair Rd.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mildred Armstrong

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Gordon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 22, 1899

8. AGE: Years	Months	Days	If less than one day
45	-0-	11	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Clinton Wolf (d)
13. Birthplace Maryland

MOTHER: 14. Maiden Name Josephine Hamlin
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location Baltimore Md

18 (a) Funeral director Wilhelm Sons Inc
(b) Address 1317 E Fort Ave

19 (a) NOV 4 - 1944 (Date rec'd by registrar)

Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1944, at 3:35AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 14, 1944, to Nov. 3, 1944, and that I last saw her alive on Nov. 2, 1944.

Immediate cause of death	Duration
Bronchopneumonia	4 days
Due to uremia, organic	7
Due to Congestive heart failure	4 mos
Due to Chronic heart disease	

Other Conditions Pulmonary infarction
Left hemiplegia old 2 yrs.
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy On above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. M. Phillips M. D.
Address Balt City Hosp Date signed 11-3-44

JL - 903 G22276

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22276 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals 12-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2604 Huntington Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Donald Baldwin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 20, 1884

8. AGE: Years	Months	Days	If less than one day
60	6	12	hr. min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Benjamin Baldwin
13. Birthplace Md.

MOTHER 14. Maiden Name Elizabeth Reynolds
15. Birthplace Md.

16 (a) Informant B. C. H. Records
(b) Address 4940 Eastern Ave.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 6-1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Balto Md

18 (a) Funeral director William Cook & Son
(b) Address 1917 St Paul St.

19 (a) (Date received by registrar) NOV 4 1944 Huntington & Williams Address

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-2- 1944, at 5 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31 1944, to 11-2 1944, and that I last saw h.i.m alive on 11-2- 1944

Immediate cause of death Bronchopneumonia — Duration 1 wk

Due to Unknown Organism — Duration

Due to Congestive Heart failure — Duration 3 wks

Arteriosclerotic Heart Disease — Duration 1 month

Other Conditions Azotemia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy: as above

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. McKelvey M. D.
Address Baltimore & Hilton Sts. Date signed 11-3-44

G22277

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22277

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2707 Eastern Ave
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2707 Eastern Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Agnes Kawecki

3 (b) If veteran, name war

3 (c) Social Security Account No. Yes

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband ~~or wife~~ Michael Kawecki
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) January 1894

8. AGE: Years	Months	Days	If less than one day
50	10		hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

MOTHER / FATHER
12. Name Matthew Sobczak
13. Birthplace Poland
14. Maiden Name Anna Studzinski
15. Birthplace Poland

16 (a) Informant Michael Kawecki
(b) Address 2707 Eastern Ave

17 (a) Burial (b) Date thereof 11-7-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto Md

18 (a) Funeral director George R Weber
(b) Address 705 S Arrington Ave Williamsport Md

NOV 4 - 1944
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3rd 1944, at 2 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 31, 1944, to Nov. 3, 1944, and that I last saw h.r alive on Nov. 3, 1944.

Immediate cause of death	Duration
Coronary occlusion	(Sudden)
Due to chronic Hypertension	
Due to	
Other Conditions None other	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur? —
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — What at work? —
(Specify type of place)
(e) Means of injury —

23. Signature John J. Kraus M. D.
Address 2677 Eastern Ave (Date signed) Nov. 3, 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22278

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G22278

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1625 W Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Elizabeth C. Lomax

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Widow

6 (b) Name of husband or wife David
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11/2/1879

8. AGE: Years	Months	Days	If less than one day
65	—	—	hr. min.

9. Birthplace Va (Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name James Redd
13. Birthplace Va

MOTHER
14. Maiden Name Park West
15. Birthplace Va

16 (a) Informant Anna Floyd
(b) Address 1624 W. Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory Middlesex Co Va
Location Va

18 (a) Funeral director Geo. W. Kelson
(b) Address 1303 Pennsylvania Ave

NOV 4 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 2 1944, at 5:45 P. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Arteriosclerosis
cardiovascular
Due to disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. Medical Examiner.
Date signed November 3, 1944.

VS 151

G22279 ✓ G22279

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 442 Huron Av
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 D
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto City
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2356 Wilkens Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Charles R. Baker Sr

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	No

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Louisa Baker
6 (c) If alive, give age 54 years
7. Birth date of deceased (mo., day, yr.) 1/19/1886 Balto. Md

8. AGE: Years	Months	Days	If less than one day
59	9	24	hr. min.

9. Birthplace Balto Md (Town, county, and state)
10. Usual Occupation Grocer
11. Industry or business Self employed

FATHER
12. Name Charles R. Baker
13. Birthplace Md

MOTHER
14. Maiden Name Margaret Donelly
15. Birthplace Md

16 (a) Informant Louisa Baker
(b) Address 2356 Wilkens Ave
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Pk
Location Balto City
18 (a) Funeral director A. Howard Evans
(b) Address 1402 Edmondson Av
NOV 5 1944
19 (a) (Date rec'd by registrar) Huntington Williams, MD

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1944, at 5:30 P M
21. I certify that death occurred on the date above stated; that I attended deceased from Dec 1943 to Nov 3 1944
and that I last saw him alive on Nov 3 1944
Immediate cause of death Coronary Thrombosis — Duration 15 min.
Due to Coronary Sclerosis
Due to Cardiac Hypertrophy — 4-5 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Theodore Cooper M. D.
Address 2107 Park Ave Date signed 11/4/44

G22280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

170c

G22280 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: ST Agnes Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) 3 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Towson
(If outside city or town limits, write RURAL and give town)
(d) Street No. 37 Allegany Ave
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Henry M. Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife ********

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years	Months	Days	If less than one day
37	?	?	hr. min.

9. Birthplace St. Mary's, Pa. (Town, county, and state)

10. Usual Occupation

11. Industry or business Glenn L. Martin Air Plane Mfgr.

FATHER
12. Name Anthony Gregory
13. Birthplace Pennsylvania

MOTHER
14. Maiden Name Margaret Schaumbauer
15. Birthplace Pennsylvania

16 (a) Informant George S. Jackson
(b) Address 415 S. VanPelt St. Phila. Pa.

17 (a) Transportation (Burial, cremation, or removal) (b) Date thereof 11/5/44 (month) (day) (year)

(c) Cemetery or crematory
Location St. Mary's Pennsylvania

18 (a) Funeral director H. W. Mears and Son
(b) Address 805 N. Calvert Street

19 (a) Date NOV 5 1944 Registrar Huntington Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION 45

20. DATE OF DEATH Nov. 4 1944 at 6 A.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushed chest, Fracture of skull

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Nov. 4 1944
(b) Where did injury occur? Frederick Ave
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? No
(d) Means of injury Auto ran into telegraph pole

23. Signature Robert L. Gerlach, M.D. Medical Examiner.
Date signed Nov. 4 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARK "X" IN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physician: please write the causes of death clearly and legibly.

G22281

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G22281 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Rutland & Laynor Ave
(c) Hospital or institution:
West Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days) 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3521 Lynchester Rd
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jacob Resnick

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widwr

6 (b) Name of husband or wife Hetta Resnick

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
72			hr. min.

9. Birthplace Poland (town, county, and state)

10. Usual Occupation Retired

11. Industry or business

FATHER 12. Name —

13. Birthplace Poland

MOTHER 14. Maiden Name

15. Birthplace Poland

16 (a) Informant Rosie Resnick

(b) Address 3521 Lynchester Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-5-44 (month) (day) (year)

(c) Cemetery or crematory Rosedale

Location

18 (a) Funeral director Jack Levin Inc

(b) Address 1439 E. Balto. St

(c) 5-11-1944 (Date filed by registrar) Huntingtown Williamsport MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1944, at 8:00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 25 1944, to Nov 3 1944, and that I last saw h[illegible] alive on Nov 3 1944.

Immediate cause of death [illegible] — Duration

Due to

Due to

Other Conditions Bronchitis
Congestive Heart failure
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

over

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible]

Address West Baltimore General Hosp. Date signed 11-3-44 M. D.

G22282

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

✓G22282 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1424 N. Gay St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1424 N. Gay St. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Charles A. Graham

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: No

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Emma E. Graham (Deceased)
6 (c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 19. 1860

8. AGE: Years: 84 Months: 0 Days: 15 If less than one day: hr. min.

9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual Occupation: Guard
11. Industry or business: Md. Penitentiary

FATHER
12. Name: Wm. J. Graham
13. Birthplace: Baltimore Md

MOTHER
14. Maiden Name: Alice A. Jones
15. Birthplace: Baltimore Md

16 (a) Informant: Mr. Graham (son)
(b) Address: 1424 N. Gay St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov. 3/44 (month) (day) (year)
(c) Cemetery or crematory: Western Cemetery
Location: Edmondson Ave. [illegible]

18 (a) Funeral director: Elmer O. Griffith & Son
(b) Address: 924 E. Eager St.

19 (a) 5-1944 (Date filed by registrar) (b) Registrar: Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3rd 1944, at 1:30 p M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939 to 11/3 1944, and that I last saw h[illegible] alive on Nov 1 1944.

Immediate cause of death: Arteriosclerotic Cardiovascular Disease with Myocardial Failure — Duration: 5 yrs.
Due to:
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public office? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: I. Karl Grossman M. D.
Address: 1212 N. Patterson Pk Ave Date signed: 11/4/44

I. Karl Grossman

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G22283 ✓ G22283

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

Every item of information should be carefully written. Please write plainly, with unfading ink. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1611 Edison Highway
(c) Hospital or institution: 26
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 5 5 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1611 Edison Highway
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Margaret L. Reinhold

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Frederick H. Reinhold 6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1862

8. AGE: Years	Months	Days	If less than one day
81	10	17	10 hr. min.

9. Birthplace Ireland (Town, county, and state)
10. Usual Occupation at home
11. Industry or business

FATHER — 12. Name	Samuel Lamond
FATHER — 13. Birthplace	Ireland
MOTHER — 14. Maiden Name	Mary Toner
MOTHER — 15. Birthplace	Ireland

16 (a) Informant Mrs. J. Hardesty
(b) Address 1807 Edison Highway
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 (month) 07 (day) 44 (year)
(c) Cemetery or crematory Baltimore
Location Balto. Md
18 (a) Funeral director Lassahn Funeral Home
(b) Address 7401 Belair Rd.
19 (a) NOV 5 1944 (Date filed by registrar) Martha [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4- 1944, at 7.05 P.M.

21. I certify that I took charge of the remains described above, held an Inspection & Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑; accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Arteriosclerotic Cardio-Vascular Disease
Due to
Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Nelson M.D.
Medical Examiner.
Date signed 11-5-44

VS 151

G22284 | BALTIMORE CITY HEALTH DEPARTMENT | G22284 Registered No.

CERTIFICATE OF DEATH 97

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 212 Stoney Run Lane
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3½ mos
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3410 Oakenshaw Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Isabel Brice Poor

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: Alfred Poor
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 17, 1867

8. AGE: Years 77 | Months 6 | Days 18 | If less than one day hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: housewife

11. Industry or business

FATHER 12. Name: William Augustus Dennington
13. Birthplace: Baltimore

MOTHER 14. Maiden Name: Sarah Brice KEENER
15. Birthplace: Baltimore

16 (a) Informant: Marion Poor Worthington
(b) Address: 3410 Oakenshaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: Nov 6 1944 (month) (day) (year)
(c) Cemetery or crematory: Green Mount
Location: Balto Md

18 (a) Funeral director: Henry W. Jenkins & Son
(b) Address: McCulloh & Richard Sts

19 (a) NOV 5 1944 (b) Registrar: Huntington Williams, M.D.

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 4 1944 at 1:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from March 1941 to Nov 4 1944 and that I last saw h[illegible] alive on Nov 3 1944

Immediate cause of death: Hypertension — Duration: 10 years
Due to: Arteriosclerosis — same
Due to
Other Conditions: Uremia — 3 days
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Alan Bernstein M. D.
Address: 1039 N Calvert St Date signed: 11/4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G22285 BALTIMORE CITY HEALTH DEPARTMENT G22285

CERTIFICATE OF DEATH 93D

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG... RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address North Broadway
(c) Hospital or institution: Church Home & Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days) 6

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Queen Anne's
(c) City or town Centerville
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Harry B. Moore

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Ola D. Moore
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1883

8. AGE: Years	Months	Days	If less than one day
61	1	23	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business Farm

FATHER
12. Name Robert Moore
13. Birthplace Md

MOTHER
14. Maiden Name Catherine Betton
15. Birthplace Delaware

16 (a) Informant Miss Grace Moore
(b) Address Church Home & Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/44 (month) (day) (year)
(c) Cemetery or crematory
Location Centreville Md

18 (a) Funeral director Harry H. Kittyle
(b) Address Kent Edmondson Ave

19 (a) (b)
(Date received by registrar) (Registrar)
NOV 5 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 – 5 1944, at 8:35 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-31- 1944, to 11 – 5 1944, and that I last saw him alive on 11- 5 1944.

Immediate cause of death Acute congestive heart failure — Duration 14 hrs

Due to Arteriosclerotic & hypertensive cardiovascular disease — Duration several years

Due to Cerebrovascular accident (right middle meningeal artery) — Duration 7 days

Other Conditions old coronary occlusion

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin H. Davis
Address Church Home Hospital M. D.
Date signed 11-5-44

G22286 — BALTIMORE CITY HEALTH DEPARTMENT — G22286

CERTIFICATE OF DEATH 43a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 518 No Bond St.
(c) Hospital or institution: –
(d) Length of stay in hospital or inst. (yrs., mos., or days) –
(e) Length of stay in Baltimore (yrs., mos., or days) 22

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 518 No. Bond. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country –

3 (a) FULL NAME Lillie Atkins

3 (b) If veteran, name war –
3 (c) Social Security Account No.

4. Sex F | 5. Color or race Colored | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Walter H. Atkins
6 (c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) August 29, 1902

8. AGE: Years 42 | Months 2 | Days 4 | If less than one day – hr. – min.

9. Birthplace Charlottesville, Va.
(Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business –

FATHER
12. Name James Allen
13. Birthplace Charlottesville, Va.

MOTHER
14. Maiden Name Alice Gray
15. Birthplace Charlottesville Va.

16 (a) Informant Susie Atkins
(b) Address 621 No. Bond St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary.
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Pennsylvania Ave
(c) NOV 5 1944 (by registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1944 at 2.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 1944 to 11/3 1944 and that I last saw him alive on 11/2 1944.

Immediate cause of death Cerebral hemorrhage — Duration

Due to Hypertension

Due to Renal disease.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Randall Lightstone M. D.
Address 2129 Druid Hill Ave Date signed 11/5/44
M Lightstone

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAKE NO ENTRIES IN SPACE RESERVED FOR BINDING

G22287 G22287

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 131a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1730 W. Lanvale St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1730 W. Lanvale St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Augustus D. Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sarah B. Johnson

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5 1877

8. AGE: Years 67 | Months 6 | Days 26 | If less than one day hr. min.

9. Birthplace Essex Co. Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Robert Johnson
13. Birthplace Va

MOTHER
14. Maiden Name Peggie Green
15. Birthplace Va

16 (a) Informant Sarah B. Johnson
(b) Address 1730 W. Lanvale St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/44 (month) (day) (year)
(c) Cemetery or crematory Mt Calvary
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Braddish Ave

19 (a) Date received NOV 3 1944 (b) Registrar

Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 1944 to Nov. 1 1944 and that I last saw h/l alive on Nov. 1 1944

Immediate cause of death
Uremia — Duration 2 wks

Due to Chronic Interstitial Nephritis — Duration 4 yrs

Due to Disease — Duration

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature R. W. Redkey M.D.
Address 426 N. John St Date signed 11/4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARG... RESERVED FO... BIDDING

G22288

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22288 Registered No. 170a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful... correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) D. o. a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Ferndale (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daniel Chase

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1929

8. AGE: Years 14 | Months 10 | Days 4 | If less than one day hr. min.

9. Birthplace Anne Arundel Co. Md. (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name Edward Chase
13. Birthplace Md.

MOTHER
14. Maiden Name Priscilla Bonds
15. Birthplace Md.

16 (a) Informant Harriett L. Edwards
(b) Address Ferndale, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/5/44 (month) (day) (year)
(c) Cemetery or crematory A. Marks.
Location Dorsey, Md.

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Brandon

19 (a) NOV 5 1944 (Date received by registrar) (b) Huntington for Williams M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH October 31, 1944, at 7:35 P. M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Fracture of Pelvis, Rupture of Bladder, Rupture of Diaphragm, left

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Oct. 31 1944 3:45 P. M.
(b) Where did injury occur? Sulphur Spring & Hammonds Ferry Rds.
(c) Did injury occur at home, on farm, industrial place, in public place? R.R. crossing While at work? No
(d) Means of injury Train hit truck
23. Signature Roland Lee Graham M.D. Medical Examiner.
Date signed Nov. 1 1944

G22289

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 52a

G22289 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2438 KEYWORTH AVE
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 39 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town BALTO.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2438 KEYWORTH AVE
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME HARRY HYMAN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife FRIEDA
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
68			hr. min.

9. Birthplace RUSSIA (town, county, and state)
10. Usual Occupation NONE
11. Industry or business

FATHER
12. Name MENDEL
13. Birthplace RUSSIA

MOTHER
14. Maiden Name GITTLE
15. Birthplace RUSSIA

16 (a) Informant WIFE
(b) Address

17 (a) BURIAL (b) Date thereof 11-5-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory ROSEDALE
Location PHIL RD + HAMILTON AVE

18 (a) Funeral director JACK LEWIS INC
(b) Address 1431 E. 33rd St.

19 (a) NOV 5 1944 (b) Registrar
(Date rec'd by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-44 19 at 9:30 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9 1944, to 11/4 1944, and that I last saw him alive on 11/4 1944.

Immediate cause of death: Hypernephroma with Multiple Metastases — Duration: 4 mo.
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hector B. Kline
Address 7904 Rust Rd Date signed 11/5/44

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied correspondence is especially important. Physicians: please write the causes of death clearly and legibly.

G22290

Duplicate

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22290 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4330 Seidel Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9
(e) Length of stay in Baltimore (yrs., mos., or days) 45y

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 543 E. 23rd St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Katie Eugene Erskine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months — | Days — | If less than one day: hr. / min.

9. Birthplace Ireland (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Patrick Bugan
13. Birthplace Ireland

MOTHER
14. Maiden Name Ann Clark
15. Birthplace Ireland

16 (a) Informant William H. Erskine
(b) Address 543 E. 23rd St.

17 (a) Burial — (Burial, cremation, or removal) (b) Date thereof 11-6-1944 (month) (day) (year)
(c) Cemetery or crematory Cathedral Cemetery
Location —

18 (a) Funeral director Mary M. Wedefeld
(b) Address 501 E. 22nd St.

NOV 5 — 1944 (Date received by Registrar) (b) Registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1944 at 2 45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1942 to Nov 3 1944 and that I last saw h[illegible] alive on Nov 3 1944.

Immediate cause of death	Duration
Cerebral Hemorrhage	18 hrs
Due to Hypertension & arteriosclerotic C-V disease	5 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W. H. Krenger M. D.
Address 1402 E. Lanvale St. Date signed 11-4-44

G22291

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46F

Registered No. G22291

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3104 Fulton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-4
(e) Length of stay in Baltimore (yrs., mos., or days) 4 months

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Carroll
(c) City or town Gamber (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edna Blanche Barnes

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1890

8. AGE: Years 54 | Months 2 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Carroll Co. Maryland. (Town, county, and state)
10. Usual Occupation Housework.
11. Industry or business

FATHER
12. Name Jabez N. Barnes
13. Birthplace Maryland.

MOTHER
14. Maiden Name Kittie Haines
15. Birthplace Maryland.

16 (a) Informant Mrs. Elsie Ward.
(b) Address 3104 Fulton Ave. City.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-44 (month) (day) (year)
(c) Cemetery or crematory Providence
Location Gamber, Carroll Co. Md.

18 (a) Funeral director E. M. Waltz
(b) Address Winfield, Md.

19 (a) NOV 6 - 1944 (Date rec'd by registrar) Huntingtn-Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1944 at 7.55 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 15 1944 to Nov 3 1944 and that I last saw h-- alive on Nov 2 1944

Immediate cause of death: Carcinoma of Liver — Duration: 1 year
Due to: Metastasis — Duration: 3 mo
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm Emmy M.D.
Address Gamber Md Date signed 11/4/44

VS 130

G22292

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 122B

Registered No. G22292

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7da
(e) Length of stay in Baltimore (yrs., mos., or days) 1

2. USUAL RESIDENCE OF DECEASED Anne Arundel
(a) State Md Balto (b) County Balto
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 4012 Pitcher Highway (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Charles E. Rupert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	M

6 (b) Name of husband or wife Dorthy Rupert
6 (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.) June 12 1910

8. AGE: Years	Months	Days	If less than one day
34	4	23	hr. min.

9. Birthplace Munsie Pa (Town, county, and state)
10. Usual Occupation Welder
11. Industry or business Md. Drydock

FATHER
12. Name John Rupert
13. Birthplace Pa

MOTHER
14. Maiden Name Mabel Sentler
15. Birthplace Pa

16 (a) Informant Mrs. Charles Rupert
(b) Address 4012 Pitcher Highway

17 (a) removal (Burial, cremation, or removal) (b) Date thereof Nov. 6/44 (month) (day) (year)
(c) Cemetery or crematory Munsie Pa.
Location

18 (a) Funeral director Fred. A. Krauss & Son
(b) Address 1216 N. Charles St.

19 (d) NOV 6 - 1944 (Date rec'd by registrar) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 19 44, at 3 10 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1944, to 11-5 1944, and that I last saw him alive on 11-5-44 19

Immediate cause of death	Duration
intestinal obstruction	10 days
Due to adh. post operative adhesions	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation 10-28-44
Major findings of operation: adhesions, obstruction
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Square Hospital Date signed 11-4-44

G22293

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G22293

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Madison & Linden
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town A. A Co. (If outside city or town limits, write RURAL and give town)
(d) Street No. Point Pleasant, Md. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Minnie Higdon

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	married

6 (b) Name of husband or wife James R. Higdon
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 28, 1873

8. AGE: Years	Months	Days	If less than one day
71	6	6	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business at home

FATHER
12. Name Leonard Heer
13. Birthplace Germany

MOTHER
14. Maiden Name Mary
15. Birthplace Germany

16 (a) Informant Mr. John A. Higdon
(b) Address 73 Hilltop Rd. Brooklyn Pk.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven
Location Glen Burnie, Md

18 (a) Funeral director John F Denny Inc C.E. Hess
(b) Address 715 Light St.

NOV 6 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/3 1944, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/30 1944, to 11/3 1944, and that I last saw her alive on 11/3 1944.

Immediate cause of death Bronchopneumonia — Duration 3 days

Due to

Due to

Other Conditions Hypertensive Cardio-Vascular Disease, Uremia.
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Md. Gen'l. Hospital Date signed 11/3/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-180

G22294

JO #9351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

13 B

✓ G22294

Registered No.

PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:
Baltimore City Hospitals

17

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 mos. 24 da.

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 629 N. Paca St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME
Alverta Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	Married

6 (b) Name of husband or wife Robert Taylor

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 3, 1919

8. AGE: Years	Months	Days	If less than one day
25	-1-	-1-	hr. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry C. Ballard (d)
13. Birthplace Virginia

MOTHER
14. Maiden Name Agnes Jackson
15. Birthplace Maryland

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof Nov 7 1944 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director A Hahn Dent

(b) Address 918

19 (a) (b) Registrar

NOV 8 1944
VS 180

Washington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1944, at 2:40AM

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 10, 1944, to Nov. 4, 1944, and that I last saw her alive on Nov. 3, 1944.

Immediate cause of death	Duration
Toxemia	
Due to Pulmonary tuberculosis	6 mos.
Due to	
Other Conditions Intestinal tuberculosis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Harold Ballard M. D.

Address Balto City Hosp Date signed 11/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Released by National Archives
Via Mr Kelly per D. Lippincott

G22295

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a

G22295 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 33rd St. East

(c) Hospital or institution: Union Memorial Hosp. 14

(d) Length of stay in hospital or inst. (yrs., mos., or days) 57 days

(e) Length of stay in Baltimore (yrs., mos., or days) 93 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1402 Bolton St.
(If rural give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isabelle Morris Bond

3 (b) If veteran, name war: no

3 (c) Social Security Account No.: none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: none

6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 28, 1851

8. AGE: Years: 93 | Months: 73 | Days: 14 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual Occupation: none

11. Industry or business:

FATHER
12. Name: Thomas E. Bond
13. Birthplace: Maryland

MOTHER
14. Maiden Name: Annie Morris
15. Birthplace: Virginia

16 (a) Informant: Miss Anne Owings
(b) Address: 125 John St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11/7/44 (month) (day) (year)

(c) Cemetery or crematory: Green Mount
Location: Balto. Md.

18 (a) Funeral director: William Cook Inc.
(b) Address: 121 St. Paul St.

19 (a) NOV 6 1944 (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1944 at 8:22 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept. 8 1944 to Nov. 4 1944 and that I last saw h[illegible] alive on Nov. 4 1944

Immediate cause of death: Cardio-respiratory failure — Duration:

Due to: Hypertensive Cardio-Vascular Disease

Due to: fracture of hip

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide: accident 14/1

(b) Date of occurrence: Oct. 5, 1944 at M

(c) Where did injury occur? Baltimore, Md.
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home While at work?
(Specify type of place)

(e) Means of injury: slipped & fell

23. Signature: [illegible] M. D.

Address: Union Memorial Hosp. Date signed: 11-7-44

VS 188

G22296

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22296 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto. Co.
(c) City or town Arbutus (If outside city or town limits, write RURAL and give town)
(d) Street No. 1234 Linden Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Elizabeth Mureay

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-78

8. AGE: Years 66 tot | Months 7 | Days 10 | If less than one day hr. min.

9. Birthplace D. C. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Wm. Seaton
13. Birthplace ?

MOTHER 14. Maiden Name Josephine Cazed
15. Birthplace ?

16 (a) Informant Rosella
(b) Address Johns Hopkins Hospital

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory Meadow Ridge
Location Dorsey Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) (b) Hunting for Witness Address

NOV 6 1944

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1944 at 7:55 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 2, 1944 to Nov. 5 1944 and that I last saw her alive on Nov. 5 1944.

Immediate cause of death: Uremia — Duration 6 days

Due to: Chronic nephritis — 4 yrs

Due to: Hypertensive Cardiovascular Disease — 4 yrs

Other Conditions: Pulmonary tuberculosis — new

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature William J. Dixon
Address Johns Hopkins Hosp. Date signed 11/5/44

G22297

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G22297

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 621 W Lafayette ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) 30 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto 12
(If outside city or town limits, write RURAL and give town)
(d) Street No. 621 W. Lafayette ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lane King

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F

5. Color or race colored

6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Joe King

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years 51 | Months | Days | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation Domestic

11. Industry or business

FATHER 12. Name —

13. Birthplace Va

MOTHER 14. Maiden Name Valecia Webster

15. Birthplace Va

16 (a) Informant Clara Walker

(b) Address 1209 W Lanvale St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn

Location md

18 (a) Funeral director George L. Nelson

(b) Address 1303 Pennsylvania Ave

19 (a) (b)

NOV 6 1944

Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 19 44, at 1:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 10-26 1944 to 11-3 1944, and that I last saw h[illegible] alive on 11-3 1944.

Immediate cause of death (Cardio-Renal)

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

8 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature B. D. Hatcher M. D.

Address 1 W Pa Ave Date signed 11-5-44

G22298 G22293

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1100 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Baltimore Maryland
(b) Street address
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A
(e) Length of stay in Baltimore (yrs., mos., or days) 14

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give name)
(d) Street No. 1004 McCulloh St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Olivia Hyman

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Female
5. Color or race: Colored
6 (a) Single, married, widowed, or divorced: S.
6 (b) Name of husband or wife: none
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 12/23/1919
8. AGE: Years 24 Months 10 Days 9 If less than one day hr. min.
9. Birthplace md (Town, county, and State)
10. Usual Occupation Domestic
11. Industry or business

FATHER 12. Name Henry Hayman
13. Birthplace N. C.
MOTHER 14. Maiden Name Rosetta Thomas
15. Birthplace Va

16 (a) Informant Rosetta Hayman
(b) Address 712 Cohen Lane
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn.
Location Md
18 (a) Funeral director Geo. B. Kelso
(b) Address 1303 Pennsylvania Ave
19 (a) NOV 6 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH November 3 19 44, at 6:30 P. M.
21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
IMMEDIATE CAUSE OF DEATH Pleurisy, acute suppurative.
Due to Pneumothorax, spontaneous.
Other Conditions Atelectasis.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

Signature H. J. Wollenmuller M.D.
Medical Examiner.
Date signed November 3, 1944.

VS 151

G22299

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22299

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Aug. 31, 1944
(e) Length of stay in Baltimore (yrs., mos., or days) Since Aug. 31, 1944

2. USUAL RESIDENCE OF DECEASED:
(a) State Dutch West Indies (b) County
(c) City or town Curacao (If outside city or town limits, write RURAL and give town)
(d) Street No. 144 Wilhelmstradt (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME ALEXANDER MARTINEZ

3 (b) If veteran, name war --

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Col.

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife ?

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/29/1917

8. AGE: Years 26 | Months 10 | Days 4 | If less than one day ... hr. ... min.

9. Birthplace Dutch West Indies (Town, county, and state)

10. Usual Occupation Cook

11. Industry or business Merchant Seaman

FATHER
12. Name ? (Parents both in Dutbh
13. Birthplace ? West Indies)

MOTHER
14. Maiden Name Maria ?
15. Birthplace ?

16 (a) Informant Records, U.S.Marine Hosp.
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Frederick Ave - City

18 (a) Funeral director STEWART & MOWEN COMPANY
(b) Address (W. F. Woodes Suc.) 100 N. South Avenue

19 (a) ... (b) ... Williams M.D.
(Signature of registrar)

NOV. 6 - 1944

MEDICAL CERTIFICATION

P.

20. DATE OF DEATH Nov. 2, 1944, at 10:20 M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 31, 1944 to Nov. 2, 1944, and that I last saw him alive on Nov. 2, 1944.

Immediate cause of death Bilateral pulmonary tuberculosis, far advanced — Duration: Unk.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation:

of autopsy: As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. C. Archer M. D.
Address Baltimore, Md. Date signed 11/3/44

Immigration-55205

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22300 ✓ G22300

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert Sts.
(c) Hospital or institution:
Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 Days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1605 Chilton Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Willis Walter Ales

3 (b) If veteran, name war	3 (c) Social Security Account No.
none	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/2/1874

8. AGE: Years	Months	Days	If less than one day
70	2	2	hr. min.

9. Birthplace Baltimore, Md.
(Town, county and state)
10. Usual Occupation Retired Dentist
11. Industry or business Technician

FATHER
12. Name Mr. Reuben Ales
13. Birthplace Maryland

MOTHER
14. Maiden Name Margaret Paddington
15. Birthplace Maryland

16 (a) Informant Mr. Stanley Ales (nephew)
(b) Address 1605 Chilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Sulivan Memorial Co.

18 (a) Funeral director 108 W Mt. Royal
(b) Address H. Gatewood

19 (a) NOV 6 1944 (Date rec'd by registrar) (b) [illegible] Registrar

VS 200

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/44 19 at 11:40 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/44 19 to 11/4/44 19, and that I last saw h[illegible] alive on 11/4/44 19

Immediate cause of death	Duration
Cardio respiratory failure	
Due to Arteriosclerosis	
Heart Disease	
Due to	
Other Conditions Renal Failure	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Stephen J. Van Lill III M. D.
Address Union Memorial Hosp. Date signed 11-4-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly. Physicians: please write correct age is especially important.

G22401 ✓ 50 G22301

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 902 S.Clinton St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 11

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 902 S.Clinton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Moltz

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M

6 (b) Name of husband or wife William
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 11,1886

8. AGE: Years	Months	Days	If less than one day
58	3	23	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation at home

11. Industry or business

FATHER
12. Name Andrew Spangler
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Lentz
15. Birthplace Baltimore Md.

16 (a) Informant William Moltz
(b) Address 902 S.Clinton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel
Location O'Donnell St.

18 (a) Funeral director Clarence F.Hoffmann
(b) Address 1639 N.Broadway.

19 (a) (Date received by Registrar) NOV 6 - 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 19 44, at 4:00AM

21. I certify that death occurred on the date above stated; that I attended deceased from October 30 44 to Nov. 3 1944, and that I last saw h. alive on Nov. 2. 1944

Immediate cause of death	Duration
Carcinoma of the mammary gland, left	1 yr.
Due to Myocardial Insufficiency	12 hrs
Due to Pulmonary Oedema	6 hrs
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature I. A. B. Bronusha, M.D.
Address 3037 O'Donnell St Date signed 11-3-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARG. RESERVED FOR BINDING

G22302 BALTIMORE CITY HEALTH DEPARTMENT G22302
CERTIFICATE OF DEATH 46B
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19 days
(e) Length of stay in Baltimore (yrs., mos., or days) 19 "

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna. (b) County Franklin
(c) City or town Chambersburg (If outside city or town limits, write RURAL and give town)
(d) Street No. R.D. #2 (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr Van Newcomer.
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Widowed.

6 (b) Name of husband or wife Daisy Sonner
6 (c) If alive, give age d. years

7. Birth date of deceased (mo., day, yr.) 12-23-67

8. AGE: Years	Months	Days	If less than one day
76	10	12	3 hr. ... min.

9. Birthplace Penna. (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Newcomer
13. Birthplace Penna.

MOTHER
14. Maiden Name Tizzy Curlett
15. Birthplace Penna

16 (a) Informant Mr. James Brindle
(b) Address R.F.D. Chambersburg, Pa.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Cedar Grove Cemetery
Location Chambersburg, Pa.

18 (a) Funeral director Fridinger & Buchanan Sons
(b) Address Bath & Pennsylvania Ave

19 (a) (Date received) Registrar

VS 116 Hunter to Wire

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5 1944, at 3:?? M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-17 1944 to 11-5 1944, and that I last saw h?? alive on 11-5 1944

Immediate cause of death Cardio-respiratory failure — Duration: —
Due to Carcinoma of Stomach & metastases — Duration: 2 mos
Due to — Duration:
Other Conditions — Duration:

(Include pregnancy within 3 months of death)
Date of operation 10-23-44
Major findings of operation: Carcinoma of Stomach & metastases.
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature Henry C. Grove M.D.
Address Union Memorial Hospital

G22303

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

97

B22303 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Garrison Blvd.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15-12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2468 Shirley Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME MARY MORAN SPICER

3 (b) If veteran, name war: none
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Thomas J.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 5, 1862

8. AGE: Years: 82 | Months: 3 | Days: 29 | If less than one day: hr. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual Occupation: Housewife
11. Industry or business

FATHER
12. Name: William Moran
13. Birthplace: Ireland

MOTHER
14. Maiden Name: Ann Gannon
15. Birthplace: Ireland

16 (a) Informant: Mr. George Spicer
(b) Address: 343 Ridge Ave., Towson

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory: New Cathedral Cem.
Location: Balto., Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

19 (a) (Date received by registrar) NOV 6 1944 (b) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1944, at 5:10 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4-44 19__, to 11-4- 1944, and that I last saw h alive on 11-4 1944

Immediate cause of death: Cardiac failure — Duration: 2 days

Due to: Arteriosclerosis — —

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Howard W. Warner M. D.
Address: 2407 Garrison Blvd. Date signed 11-4-44

G22304 ✓ G22304

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

938 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Cayuga Ave + Dukeland St.
(c) Hospital or institution: Md. Balt. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2933 Belmont Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Florence R. Logue

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William S. Logue

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) unknown 1858

8. AGE: Years 86 | Months | Days | If less than one day hr. min.

9. Birthplace Balto., Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business —

FATHER
12. Name John Rites
13. Birthplace Md.

MOTHER
14. Maiden Name Miranda Buckingham
15. Birthplace Md.

16 (a) Informant Miss Alice A. Colladay
(b) Address 2905 Belmont Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (b) Registrar

NOV 6 1944 Huntington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1944, at 12:20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/22 1944 to 11/5 1944, and that I last saw ~~her~~ alive on 11/5 1944.

Immediate cause of death	Duration
Acute C.V.D.	
Due to (antecedent) Generalized arteriosclerosis	
Due to Cardiac embarrassment & insufficiency.	
Other Conditions Senility (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy Cardiac embarrassment Severe generalized arteriosclerosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Irving J. Taylor M.D.
Address 1 W Bclf Date signed 11/5/44

Burial
G22305
2.30 pm

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

G22305
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1810 N. Bentalou St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1810 N. Bentalou St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FLORA W. PETERS

3 (b) If veteran, name war --
3 (c) Social Security Account No. --

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife Rev. T. E. Peters
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10, 1862

8. AGE: Years 82 | Months 3 | Days 24 | If less than one day hr. min.

9. Birthplace Clarksburg, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William R. Windsor
13. Birthplace Md.

MOTHER
14. Maiden Name Annie Murphy
15. Birthplace Md.

16 (a) Informant Mr. William Windsor, Brother
(b) Address 3048 W. North Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Balto., Md.

18 (a) Funeral director Wm. J. TICKNER & SONS
(b) Address Balto., [illegible] Washington Boulevard

19 (a) [illegible] (b) [illegible]
(Accepted by registrar) Registrar

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1944 at 12:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 10 1944 to Nov 4 1944 and that I last saw h[illegible] alive on Nov 3 1944.

Immediate cause of death	Duration
Myocardial Insufficiency	3 yrs -
Due to Arterio-sclerosis	10 yrs
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature G W Bellis M. D.
Address 2224 W. North Ave. Date signed Nov 4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write th[illegible] to the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Released by Medical Examiner
Dr. McNally per Dr. Lyon

G22306 ✓ G22306

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 186a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp. 17
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 Mo. 9d.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore 2 (If outside city or town limits, write RURAL and give town)
(d) Street No. 3435 University Place (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME STELLA WOODROW

3 (b) If veteran, name war	3 (c) Social Security Account No.
no	no

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife William H. R. Woodrow
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 4/11/1876

8. AGE: Years	Months	Days	If less than one day
68	6	23	hr. min.

9. Birthplace Maryland (Madonna) (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name George Lemmon
13. Birthplace Maryland

MOTHER
14. Maiden Name Mary Jane King
15. Birthplace Maryland

16 (a) Informant Mr. Wm. H. R. Woodrow
(b) Address 3435 University Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory Bethel Cem.
Location Harford Co., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams (Signature of registrar)

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/44 19 . at 11:40 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/44 19 , to 11/7/44 19 , and that I last saw h[illegible] alive on 11/7/44 19

Immediate cause of death	Duration
Cardiorespiratory Failure	
Due to Arteriosclerotic Heart Disease	
Due to Fracture of Hip.	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: 3:08
(a) Accident, suicide, or homicide Accident
(b) Date of occurrence June 26 1944 at 6:00 P.M.
(c) Where did injury occur? 317 Mundash Rd. (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? At home While at work? No (Specify type of place)
(e) Means of injury Fell through the hall to the floor

23. Signature Glenn Frost M. D.
Address Union Memorial Hosp. Date signed 11-8-44

Approved: Huntington Williams M.D. per Registrar
Dr. McNally Actg. Chief Div. Vital Statistics
Dr. Frater M.D. 11/9/44

G22307

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 44a

G22307 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd & Calvert Sts
(c) Hospital or institution: Union Memorial Hosp. 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 hrs 25
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 3607 Fairfield Ave. Fairview (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME: HELEN VIRGINIA WORTHINGTON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife Mr. Richard [illegible] Worthington
6 (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 3-8-82

8. AGE: Years	Months	Days	If less than one day
62	7	26	____ hr. ____ min.

9. Birthplace Balto, Md. (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name Francis Carver
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Virginia Fairchild
15. Birthplace Balto, Md.

16 (a) Informant Mr. Richard [illegible] Worthington (WORKER)
(b) Address 3607 Fairview Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) ____ (Date received by registrar) (b) [illegible] Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1944 at 5:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1944 to 11-4 1944 and that I last saw her alive on 11-4 1944

Immediate cause of death: Cardio-respiratory failure — Duration: ____

Due to: Coronary occlusion. — Duration: 12 hrs.

Due to: ____

Other Conditions: ____

(Include pregnancy within 3 months of death)

Date of operation: ____

Major findings of operation: ____

of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ (Specify type of place) While at work? ____
(e) Means of injury ____

23. Signature Stephen J. VanRiell III M. D.
Address Union Memorial Hosp. Date signed 11-4-44

OVER

G22308

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 47

Registered No. G22308

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution: Franklin Square Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 7 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
City or town Baltimore 2
(If outside city or town limits, write RURAL and give town)
(c) Street No. 2709 Southern Ave
(If rural give location)
(d) Citizen of foreign country? and (Yes or No)
If yes, name country

3 (a) FULL NAME Clyde Charles Gladden

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Viola Koppel

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-5-89

8. AGE: Years	Months	Days	If less than one day
55	1 0	2 9	hr. min.

9. Birthplace Deals Island Md.
(Town, county, and state)

10. Usual Occupation Cutter

11. Industry or business

FATHER
12. Name Chas Gladden
13. Birthplace Md

MOTHER
14. Maiden Name Charlotte Jones
15. Birthplace Md

16 (a) Informant Viola Koppel Gladden
(b) Address 2709 Southern Ave

17 (a) Burial (b) Date thereof 11-8-44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Loudon Park
Location

18 (a) Funeral director L. V. Rusch
(b) Address 5305 Harford Rd.

19 (a) Huntington Hillsmere M.P.

NOV 6 — 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1944, at 6 45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-7 1944, to 11-4 1944, and that I last saw h and alive on 11-4 1944.

Immediate cause of death Carcinomatosis — Duration 2 yrs

Due to Ca of left lung

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation:

of autopsy: Ca of left lung

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 11/5/44
M. D.

G22309

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

G22309 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 14 ao Caroline St.
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore Parkdale
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2478 Kingsway - Dundalk
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country Yes.

3 (a) FULL NAME Baby Koebfleisch KALB Fleisch

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/31/44

8. AGE: Years | Months | Days 4 3 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation child

11. Industry or business

FATHER
12. Name John Kalbfleisch.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Mildred Frampton FRAMPTON
15. Birthplace Baltimore Md

16 (a) Informant Next Hospital or Father.
(b) Address

17 (a) Burial (b) Date thereof 11/6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oaklawn
Location Baltimore

18 (a) Funeral director Leonard J. Luck
(b) Address 5305 Harford Rd Woodbourne

19 (a) NOV 6 - 1944
(Date received by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1944, at M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/31 1944, to 11/4 1944, and that I last saw her alive on 11/4 1944.

Immediate cause of death Bronchopneumonia — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Hallin E Eklund

Address St Joseph Hosp Date signed 11/7/44 M. D.

G22310

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

195E

G22310 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp. 19
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Eagle St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) NAME Lloyd King alias James Lee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Emma Lee

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1907

8. AGE: Years 37 | Months 2 | Days 19 | If less than one day: hr. min.

9. Birthplace Norfolk, Va.
(Town, county, and state)

10. Usual Occupation Stevedore

11. Industry or business

FATHER
12. Name unknown.
13. Birthplace Va.

MOTHER
14. Maiden Name unknown.
15. Birthplace Va.

16 (a) Informant Emma Lee.
(b) Address 1813 Eagle st.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/44 (month) (day) (year)

(c) Cemetery or crematory Mt. Calvary
Location A. L. Co. Md.

18 (a) Funeral director Chas. H. Alexander.
(b) Address 920 N. Mount st

19 (a) [illegible] (b) [illegible]
(Signature of local registrar) (Registrar)

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1944, at 12 55 PM

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Dislocation, 4th Cervical vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following: Pier 5, Locust Pt. + 24
(a) Date of injury Nov. 3 1944 10 PM
(b) Where did injury occur? Ryan Stevedoring Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? yes
(d) Means of injury Struck by packing case

23. Signature Robert Lee Gratton M.D.
Medical Examiner.
Date signed Nov. 3 1944

(OVER)

G22311

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

14

G22311 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9-1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. St Elizabeth Home 3725 Ellerslie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Barnes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
1			hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Child

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Pearl Cecelia Barnes
15. Birthplace Md.

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/6/1944 (month) (day) (year)
(c) Cemetery or crematory Druid Hill
Location Baltimore Co. Md

18 (a) Funeral director J. B. Slaughter & Son
(b) Address 21 S. Eutaw St

19 (a) NOV 6 1944 (b) Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1944 at 10 5/6 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944 to Nov 4 1944 and that I last saw h[illegible] alive on Nov 4 1944

Immediate cause of death ? Tuberculous meningitis
Malnutrition, Anemia

Duration
1 week
? Life

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Rustin McIntosh M.D.
Address Johns Hopkins Hospital Baltimore, Md. Date signed 11/4/44

G22312

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians: please write the correct age is especially important.

MARG... RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 427 S. Ellwood Ave
(c) Hospital or institution: Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore-24 (If outside city or town limits, write RURAL and give town)
(d) Street No. 431 S. Ellwood Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Julia Zacharski

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widow

6 (b) Name of husband ~~Wife~~ Edmund

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 29th, 1865

8. AGE: Years	Months	Days	If less than one day
79	1	5	hr. min.

9. Birthplace Mariette, Wis. (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William Hoppe
13. Birthplace Prussia

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Casimir Zacharski (Son)
(b) Address 427 S. Ellwood Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-44 (month) (day) (year)
(c) Cemetery or crematory Holy Rosary
Location Baltimore, Md.

18 (a) Funeral director George R Weber
(b) Address 705 South Ann Street

19 (a) (Date received) NOV 6 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4th 1944, at 12 05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Nov 4 1944, and that I last saw h~~er~~ alive on Nov 4 1944

Immediate cause of death: Cerebral Thrombosis — Duration 4d

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Dwight Tourkey M. D.
Address 441 S. Ellwood Ave Date signed 11/5/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 152

G22313 ✓ Registered No. G22313

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Harford Rd.
(c) Hospital or institution: Sydenham Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 69 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 724 A. Aisquith St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James Wilson

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Married

6 (b) Name of husband or wife Ethel Wilson
6 (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) April 2-1872

8. AGE: Years	Months	Days	If less than one day
72	7	3.	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Septone
11. Industry or business Church Septone.

FATHER
12. Name Joseph Wilson
13. Birthplace Pa.

MOTHER
14. Maiden Name Jennie Knopf.
15. Birthplace Md.

16 (a) Informant Son-in-law
(b) Address 724 Aisquith St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-44. (Month) (Day) (Year)
(c) Cemetery or crematory Mt. Olivet Cemetery
Location Frederick Rd.
18 (a) Funeral director Mayfield & Humphreys
(b) Address 1501 N. Broadway
19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

NOV 6 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1944, at 2:00 A M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1944 to 11/5 1944, and that I last saw h.. alive on 11/5 1944

Immediate cause of death Resp. Failure — Duration: 2 days

Due to Laryngeal Obstruction

Due to

Other Conditions Carcinoma, Face

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations: Tracheotomy

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Margaret M. D. Smith M. D.
Address Sydenham Hospital Date signed 11-5-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22314

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46E

G22314 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital 26-10

(d) Length of stay in hospital or inst. (yrs., mos., or days) 51 da.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or Town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 North East Ave (If rural give location)
(e) Citizen of foreign country? N.O (Yes or No)
If yes, name country

3 (a) FULL NAME William Ernest White

3 (b) If veteran, name war –

3 (c) Social Security Account No. 214-03-7595

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Helen White
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-11-91

8. AGE: Years	Months	Days	If less than one day
53	5	24	hr. min.

9. Birthplace Maryland. (Town, county, and state)
10. Usual Occupation Trolley operator.
11. Industry or business

FATHER
12. Name White
13. Birthplace Md

MOTHER
14. Maiden Name Alice Shores
15. Birthplace Md

16 (a) Informant Mrs Helen R. White
(b) Address 7 N. East Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Baltimore

18 (a) Funeral director Philip Henry Sons
(b) Address 2024 Orleans St

19 (a) NOV 6 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4 1944, at 7:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9-9-44 1944, to 11-4 1944, and that I last saw him alive on 11-4 1944.

Immediate cause of death Cardio respiratory Failure — Duration

Due to Carcinoma of Colon + Metastatic carcinoma

Due to Carcinoma of Colon + Metastatic carcinoma

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 9-11-44
Major findings of operation: Carcinoma + carcinoma Tonis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Eugene J. Riley M. D.
Address St Joseph's Hospital Date signed 11-4-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

G22315

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

107

Registered No. G22315

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3324 Calvert St.
(c) Hospital or institution:
Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 26 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2939 Presbury St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Carrie Riefle

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 12, 1853

8. AGE: Years	Months	Days	If less than one day
91	1	21	____ hr. ____ min.

9. Birthplace Md.
(Town, county, and state)

10. Usual Occupation None.

11. Industry or business

FATHER
12. Name Henry Riefle
13. Birthplace Germany

MOTHER
14. Maiden Name Josphina
15. Birthplace Germany

16 (a) Informant Miss Henrietta Hoffhaus
(b) Address 3702 Sylvan Drive

17 (a) Burial (b) Date thereof Nov 6/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Greenmt Ave & North Ave

18 (a) Funeral director John Ottenbreit Sons
(b) Address 1900 Eutaw Place

19 (a) ____ (b) Huntington Nelligan, M.D.
(Date rec'd by registrar) Registrar

NOV 7 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1944 at 3:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-9 1944 to 11-3 1944
and that I last saw her alive on 11-3 1944
Immediate cause of death Cardiorespiratory failure — Duration
Due to Pneumonia — 26 days
Due to ____
Other Conditions ____
(Include pregnancy within 3 months of death)
Date of operation ____
Major findings of operation: ____
of autopsy: ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ____
(b) Date of occurrence ____ at ____ M.
(c) Where did injury occur? ____
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ____ While at work? ____
(Specify type of place)
(e) Means of injury ____

23. Signature Geo. Ira Harrington Jr. M. D.
Address 332 E. University Pkwy Baltimore signed 11/7/44

G22316

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 170c

G22316 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: West Balto. Gen. Hospital 15
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-4
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2711 Chelsea Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John Allen Colburn (Colbourn)

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 6/29/1936

8. AGE: Years 8 | Months 4 | Days 5 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md.
(Town, county, and state)

10. Usual Occupation student

11. Industry or business

FATHER
12. Name Edward B. Colburn
13. Birthplace Md

MOTHER
14. Maiden Name Blanche E. Haslup
15. Birthplace Md

16 (a) Informant Edward B. Colburn
(b) Address 2711 Chelsea Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 6/44 (month) (day) (year)

(c) Cemetery or crematory Lorraine
Location Govanstown, Balto Co. Md.

18 (a) Funeral director John O. Mitchell & Sons
(b) Address 1900 Eutaw Place

19 (a) Filed by (signature) (b) Huntington Hitchcock, M.D.

VS 151

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-4- 1944, at 12-35 P.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Crushed Skull.
avulsion of brain.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following: 15/8

(a) Date of injury 11-4 at 11.55 A M.

(b) Where did injury occur? 2700 block Allendale Road

(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No

(d) Means of injury Playing: run over by auto-truck

23. Signature Howard J. Mueller M.D.
Medical Examiner.

Date signed 11-4-44

G22317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

Registered No. G22317

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Baltimore Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 Hilton Ave., Catonsville, Md.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME ALBERT B. BEADLE

3 (b) If veteran, name war	3 (c) Social Security Account No.
✓	✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Ellen Congdon Beadle
6 (c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) May 11, 1868

8. AGE: Years	Months	Days	If less than one day
86	6	26	hr. min.

9. Birthplace Connecticut (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Rev. Elias R. Beadle
13. Birthplace New York

MOTHER
14. Maiden Name Marcha Ruth Yale
15. Birthplace Connecticut

16 (a) Informant Ellen Congdon Beadle
(b) Address 506 Hilton Ave. Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8/44 (month, day) (year)
(c) Cemetery or crematory Loudon Park
Location 3801 Frederick Ave.

18 (a) Funeral director John Oursler Hoyle
(b) Address 1940 Eutaw Place

19 (a) NOV 6 1944 (b) Huntington Williams
Registrar

VS 110

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1944, at 11:20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 29 1944, to November 5 1944, and that I last saw her alive on November 5 1944

Immediate cause of death	Duration
Cardio-respiratory failure	
Due to Arterio sclerotic heart disease (? auricular fibrillation)	
Due to	
Other Conditions Paget's disease and fractured (pathological) left femur (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Glenn O. Bran M. D.
Address Union Memorial Hosp Date signed 11-5-44

G22318

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

126 Registered No. G22318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6D
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County 11
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 11 Club Road, City (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mamie Seeware (Mamie Stewart)

3 (b) If veteran, name war ✓ | 3 (c) Social Security Account No. ✓

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Hyland P. Stewart deceased 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1862

8. AGE: Years	Months	Days	If less than one day
82	6 9	3	hr. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name William H Adams
13. Birthplace Md.

MOTHER
14. Maiden Name --- Beale
15. Birthplace

16 (a) Informant Mr. Hyland P. Stewart
(b) Address 11 Club Road

17 (a) Interment (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Lorraine
Location Powhatan

18 (a) Funeral director John Ourtchyll Towns
(b) Address 900 Eutaw Place

19 (a) Filed (Signature of registrar) (b) Nov. 7, 1944 Registrar

VS 100

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1944 at 8:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from October 28 1944, to November 5 1944, and that I last saw her alive on Nov. 5 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Arterio sclerotic heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation November 2, 1944
Major findings of operation: Cholecystitis
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan M. D.
Address U. M. H. Date signed 11/6/44

G22319

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22319 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1514 Division St.
(c) Hospital or institution: Provident Hospital 6-5
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 7 N Bond St (If rural give location)
(e) Citizen of foreign country? Inc (Yes or No) If yes, name country

3 (a) FULL NAME Baby Benjamin

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Negro

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years | Months | Days | If less than one day: 1 — hr. — min.

9. Birthplace Balto md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Robert Benjamin
13. Birthplace Lynchburg S.C.

MOTHER 14. Maiden Name Mattie Wilson
15. Birthplace Marysville S.C.

16 (a) Informant Robert Benjamin
(b) Address 7 N. Bond St

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location

18 (a) Funeral director
(b) Address

NOV 6 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10-17-44 1944, at 10 55 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16-44 19 to 10-17-44 19 and that I last saw h[illegible] alive on 10-17-44 19

Immediate cause of death Prematurity 6½ Months — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Marvin Adams, M. D.
Address 312 E 23rd St Date signed 11-7-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully prepared. Physicians: please write the causes of death clearly and legibly.

VS 110 Kept for anatomical purposes

G22320

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22320 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1643 E. North Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8-5
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1643 E. North Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME THRESA EISENHARDT

3 (b) If veteran, name war: no

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 14, 1858

8. AGE: Years 86 | Months 2 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore
(Town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name Anthony Eisenhardt
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Bayline
15. Birthplace Germany

16 (a) Informant Bertha Elizabeth Eisenhardt
(b) Address 1643 E. North Avenue

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-6-44 (month) (day) (year)
(c) Cemetery or crematory Parkwood Cemetery
Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Avenue & Broadway

19 (a) 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 2 1944, at 7.15P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 15 1943 to Nov 2 1944 and that I last saw h[illegible] alive on Nov 15 1944

Immediate cause of death: Myocarditis — Duration

Due to: Arteriosclerosis

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: A. W. Sander

Address 1617 N. Broadway Date signed 11/3/1944 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

VS 150

G22321

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22321 Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2798 W. North Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2798 W. North Ave. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME GEORGE FREDERICK BRIGGEMAN

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: 212-18-7040

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Veola Frances Harwood
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Mar. 3. 1871

8. AGE: Years	Months	Days	If less than one day
73	8	-	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Timekeeper
11. Industry or business Beth. Steel Co.

FATHER
12. Name ? Briggeman
13. Birthplace Baltimore

MOTHER
14. Maiden Name Not Known
15. Birthplace Baltimore

16 (a) Informant Mrs. Veola F. Briggeman
(b) Address 2798 W. North Ave.

17 (a) Nov. 1944 (Burial, cremation, or removal) (b) Date thereof 11-7-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet Cem.
Location Baltimore Md

18 (a) Funeral director HENRY SANDER & SONS. INC.
(b) Address North Ave. & Broadway

19 (a) (b) Date Nov 6 1944 Huntington Williams, M Registrar

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3. 1944 at 12.20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 19 1943 to Nov 3 1944 and that I last saw h[illegible] alive on Nov. 3, 1944.

Immediate cause of death	Duration
Arteriosclerosis	4 Yrs
Due to Chronic Myocarditis	4 Yrd
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature [signature] M. D.
Address 2757 W North Date signed 11/3/44

G22322

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22322 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 404.S. Ann. St
(c) Hospital or institution:
at home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404.S.Ann St
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Captain Frank J. Pipla

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	single

6 (b) Name of husband or wife single

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb.2.1882

8. AGE: Years	Months	Days	If less than one day
62	9	2	hr. min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual Occupation Retired Ship Captain

11. Industry or business

FATHER 12. Name Anton Pipla
13. Birthplace Austria

MOTHER 14. Maiden Name Anna Jrotz
15. Birthplace Austria

16 (a) Informant Anna Smith
(b) Address 404.S Ann St

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road

18 (a) Funeral director Lilly & Sellers Inc-a
(b) Address 403.S Wolfe. St

19 (a) (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov.4.1944 19 , at 7.30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 to 4 19 , and that I last saw h alive on Nov. 4 1944.

Immediate cause of death Cerebral Hemorrhage — Duration 11/3/44

Due to Generalized Arteriosclerosis — 11/1/43

Due to Chronic Myocarditis — 11/1943

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature William J. Bauer M.D.
Address 801 N Kenwood Ave Date signed Nov 5 1944

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correspondence is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

10-5-1944

G22323 — Workers — G22323

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

1248

Registered No. G22323

PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1300 N Caroline St

(c) Hospital or institution: St. Joseph's Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 da

(e) Length of stay in Baltimore (yrs., mos., or days) 6 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County

(c) City or town Baltimore 24

(If outside city or town limits, write RURAL and give town)

(d) Street No. 3227 O'Donnell St (If rural give location)

Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME John F Wenker

3 (b) If veteran, name war: NO

3 (c) Social Security Account No. 213 05 0635

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Caroline Wenker

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9/25/83

8. AGE: Years 61 Months 8 Days 9 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Engineer

11. Industry or business

FATHER

12. Name John B. Wenker

13. Birthplace Balto., Md

MOTHER

14. Maiden Name Fredericka Slateman

15. Birthplace Balto., Md

16 (a) Informant Caroline Wenker (wife)

(b) Address 3227 O'Donnell Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/7/44 (month) (day) (year)

(c) Cemetery or crematory Sacred Heart

Location German Hill Road

18 (a) Funeral director Lee & Gaines Sons

(b) Address 403 S. Wolfe Street

19 (a) NOV 6 1944 (Date rec'd by registrar) (b) Huntington Williams M.R. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1944 at 12:45 A

21. I certify that death occurred on the date above stated; that I attended deceased from 10/19 1944 to 11/4 1944 and that I last saw h[illegible] alive on 11/4 1944.

Immediate cause of death

Pulmonary Embolism

Due to Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 11/2/44

Major findings of operation: Coronary Thrombosis

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Harvey E. Wallace M. D.

Address 1400 N. Caroline Date signed 11/4/44

WALKup.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Name of deceased is especially important.

G22324

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22324 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 23½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED: Baltimore
(a) State Md. (b) County None
(c) City or town Baltimore Overlea
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6921 Beech Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Thomas Lance

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mrs. Francis C. Lance
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 18, 1878

8. AGE: Years	Months	Days	If less than one day
66	6	18	17 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Tavern Owner
11. Industry or business

FATHER
12. Name James J Lance
13. Birthplace Balto. Co. Md

MOTHER
14. Maiden Name Laura E Ellis
15. Birthplace Balto. Co. Md

16 (a) Informant Mrs. W.T. Lance
(b) Address 6921 Beech Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11 10 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Balto City Md.

18 (a) Funeral director Leasendale Funeral Home
(b) Address 7401 Belair Rd

19 (a) (Date received by registrar) (b) Huntington Williams M.D. Registrar

NOV 6 - 1944
VS 194

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1944, at 1:35 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/1944, to 11/5/1944, and that I last saw him alive on 11/5/1944

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. L. McJunkin M. D.
Address 7d. Bel. Road Date signed 11-5-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22325

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22325 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3 N. Chapel Street
(c) Hospital or institution: 4

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3 N. Chapel Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Phillip J. Buenger (c) Buenger

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Frances
6 (c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Nov. 1 1890

8. AGE: Years 54 | Months | Days 2 | If less than one day hr. min.

9. Birthplace Balto (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Albert Buenger
13. Birthplace Balto

MOTHER
14. Maiden Name Christine Meyers
15. Birthplace Germany

16 (a) Informant Frances Buenger
(b) Address 3 N. Chapel St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6 44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location 4300 Belair Rd

18 (a) Funeral director Mart. W.E. Dippel
(b) Address 373 Cumb St

19 (a) NOV 6-1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 181

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3, 1944, at 10 A. M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to [illegible] death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary occlusion.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. L. Wallenmeyer M.D. (Medical Examiner.)
Date signed November 3, 1944.

G22326

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55c

G22326 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2724 Elliott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1-4
(e) Length of stay in Baltimore (yrs., mos., or days) 42 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2724 Elliott st. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mikolaj Pawlak
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Tekla (Tillie) Pawlak
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Dec 6 1890
8. AGE: Years 53 | Months 10 | Days 28 | If less than one day hr. min.
9. Birthplace Poland (Town, county, and state)
10. Usual Occupation Tavern
11. Industry or business own business

FATHER
12. Name Wawrzyniak Pawlak
13. Birthplace Poland

MOTHER
14. Maiden Name Maryanna
15. Birthplace Poland

16 (a) Informant Mrs. Tekla (Tillie) Pawlak
(b) Address 2724 Elliott St.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus ht.
Location Dundalk ave
18 (a) Funeral director Stephen J. Kalkowski
(b) Address 1000 S. Kenwood Ave
19 (a) 1944 (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1944 at 4:30 P.M.
21. I certify that death occurred on the date above stated; that I attended deceased from July 10 1944 to Nov. 4 1944 and that I last saw h alive on Nov. 4 1944

Immediate cause of death	Duration
Carcinoma of Thyroid.	6 mos.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation July 28-1944
Major findings of operation Carcinoma Thyroid
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury
23. Signature John V. Szczubiak M.D.
Address 1802 Eastern Ave Date signed 11-4-44

G22327

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1216

G22327
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARG. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert st.
(c) Hospital or institution: The Mercy Hospital 9-7
(d) Length of stay in hospital or inst. (yrs., mos., or days) 24 days
(e) Length of stay in Baltimore (yrs., mos., or days) 55 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balt.
(c) City or town Balt.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1752 Homestead st.
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Italy

3 (a) FULL NAME Leo Pistorio
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, (widowed), or divorced.
M	W	Widower

6 (b) Name of husband or wife AGOSTINA PISTORIO
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 3rd 1868

8. AGE: Years	Months	Days	If less than one day
76	3	1	hr. min.

9. Birthplace Italy (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Joseph Pistorio
13. Birthplace Italy (GIOSTRA PALERMO)

MOTHER
14. Maiden Name MARIA COSTA
15. Birthplace Italy (Lena Messina)

16 (a) Informant Daughter LENA MONFREDO
(b) Address 1752 Holmestead ST.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8-1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balt. Md.

18 (a) Funeral director Frank Della Rose
(b) Address 52 N. Marley st

19 (a) (b) Registrar

NOV 6 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 19 44 at 7 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 19 44 to Nov 4 19 44, and that I last saw h[illegible] alive on Nov. 4 19 44.

Immediate cause of death Cardiac failure.
Due to C.V. decompensation
Due to Chronic nephritis.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

Duration unknown

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. H. Osborne M. D.
Address Mercy Hosp. Date signed 11-4-44

Huntington Williams M.D.

CAGE

G22328

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

Registration No. G22328

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1706 Patapsco St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 23

(e) Length of stay in Baltimore (yrs., mos., or days) 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Balto City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1706 Patapsco St
(If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME Thomas E Cage

3 (b) If veteran, name war No

3 (c) Social Security Account No. 705-09-2973

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Grace E Cage

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Aug 22, 1874

8. AGE: Years 70 | Months 2 | Days 13 | If less than one day ____ hr. ____ min.

9. Birthplace Hanford Va
(Town, county and state)

10. Usual Occupation Crew Dispatcher

11. Industry or business Bro R.R

FATHER
12. Name Henry Cage
13. Birthplace Md

MOTHER
14. Maiden Name Mary Turner
15. Birthplace Va

16 (a) Informant Grace E Cage

(b) Address 1706 Patapsco St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof Nov 9 1944 (month) (day) (year)

(c) Cemetery or crematory Wingdon Mem. Pk

Location Hartford Co Md

18 (a) Funeral director E. Howard Ellis

(b) Address 1400 Abbalon St

19 (a) NOV 6 1944 (b) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5, 1944, at 6.15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 16 1942 to Nov 5 1944 and that I last saw him alive on Nov 5 1944.

	Duration
Immediate cause of death: Exhaustion	3 Days
Due to: Cerebral Hemorrhage	16 Mos
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. C. H. Campbell M. D.

Address 644 Hamm Date signed 11/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Correct age is especially important.

MARGIN RESERVED FOR BINDING

G22329

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22329 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Caton & Wellens Ave
(c) Hospital or institution: St Agnes Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. Edmondson Ave opt Pikesville Md (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward N Phoney

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 15 1865

8. AGE: Years	Months	Days	If less than one day
78	11	18	hr. min.

9. Birthplace Maryland (town, county, and state)

10. Usual Occupation Road Superviser

11. Industry or business

FATHER — 12. Name Michael Phoney
13. Birthplace Germany

MOTHER — 14. Maiden Name Margaret Blum
15. Birthplace Germany

16 (a) Informant Mrs Mabel Fritz
(b) Address Catonsville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-44 (month) (day) (year)
(c) Cemetery or crematory Catholic
Location Balto Md

18 (a) Funeral director Guy A Farley
(b) Address Catonsville Md

19 (a) NOV 6 - 1944 (Date received by registrar) Registrar Huntington Pikesville Md

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 3 1944, at 3 P M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct 28 1944, to Nov 3 1944, and that I last saw h Live alive on Nov 3 1944.

Immediate cause of death Coronary Thrombosis

Due to Arteriosclerosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Coronary Occlusion

Arteriosclerosis - Bilateral

of autopsy: Hydrothorax

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm Lee Lee Fort

Address 20 E Pratt St Date signed 11/6/44 M D

G22330

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22330 Registered No.

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1523 N. Bentlou St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1523 N. Bentlou St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lula Linda

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	widow

6 (b) Name of husband or wife late Paul R.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 29 1869

8. AGE: Years	Months	Days	If less than one day
75	2	4	hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER: 12. Name Benjiam Wirts
13. Birthplace U. S. A.
MOTHER: 14. Maiden Name Laura Lancaster
15. Birthplace England

16 (a) Informant Mrs. Myrtle Hilton
(b) Address 1523 N. Bentlou St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A. Wilkie
(b) Address 4101 Edmondson Ave

19 (a) (Date received by registrar) (b) Registrar

NOV 6 1944
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 3 1944, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1939 to Nov 3 1944, and that I last saw him alive on Nov 1 1944

Immediate cause of death

	Duration
Coronary Occlusion	✓
Due to Generalized Arteriosclerosis	✓
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: ✓
of autopsy: not done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓ at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury ✓

23. Signature Celia A. Lancaster
Address 42 19 Ogden Date signed 11/7/44

Finster

G22331 BALTIMORE CITY HEALTH DEPARTMENT G22331

CERTIFICATE OF DEATH 477

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every question must be answered. Physicians: please write the exact age in especially important. Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1230 Federal St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 25 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1230 Federal St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Raymond L. Finster

3 (b) If veteran, name war — 3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Maude Brummel

6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Feb 10-1881

8. AGE: Years 63 | Months 8 | Days 25 | If less than one day hr. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual Occupation Plumber

11. Industry or business

FATHER 12. Name Jesse Finster
13. Birthplace Maryland

MOTHER 14. Maiden Name Sarah Smith
15. Birthplace Maryland

16 (a) Informant Maude Finster
(b) Address 1230 Federal St. Balto Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/44 (month) (day) (year)
(c) Cemetery or crematory Wesley
Location Carroll Co. Md

18 (a) Funeral director Edw C Tipton
(b) Address Hampstead Md

19 (a) NOV 6 1944 (Date received by registrar) (b) Huntington Williams, M.D.
VS

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 5 1944 at 4:03 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1944 to Nov. 5 1944 and that I last saw him alive on Nov. 5 1944.

Immediate cause of death: Carcinoma, left lung — Duration 9 mos.

Due to

Due to

Other Conditions Cerebral thrombosis
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature W. H. Kramer, M.D.
Address 1402 E Lanvale Date signed 11-6-44

M. D. R. 1209-a

G22332

HEALTH DEPARTMENT—CITY OF BALTIMORE

G22332

CERTIFICATE OF DEATH

V V 95 c

1. PLACE OF DEATH

Registered No.

CITY OF BALTIMORE: (No. 6009 Greenspring Ave St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 4 yrs. 4 mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME James Buchanan Shera

(a) Residence: No. 6009 Greenspring Ave St., 27 Ward.
(Usual place of abode) (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. Color or Race	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Simon Shera

6. DATE OF BIRTH (month, day, year) Dec 8 1856

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	10	28	

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Paper manufacturer

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. Paper mill

10. Date deceased last worked at this occupation (month and year) 1942

11. Total time (years) spent in this occupation 32

12. BIRTHPLACE (city or town) (State or country) Shera's Landing Harford Co Md

FATHER

13. NAME Daniel Turner Shera

14. BIRTHPLACE (city or town) (State or country) Liverpool England

MOTHER

15. MAIDEN NAME Jane McDarah

16. BIRTHPLACE (city or town) (State or country) Shrewsbury Ireland

17. INFORMANT Arthur J Shera

(Address) 6009 Greenspring Ave

18. BURIAL, CREMATION, OR REMOVAL

Place Burial Date Nov 8, 1944

19. UNDERTAKER H L Bailey

(Address) Darlington

FILED 11-7-44 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, year) 11-6, 1944

22. I HEREBY CERTIFY, That I attended deceased from 11-6, 1944 to 11-6-, 1944

I last saw him alive on 11-6, 1944 Death is said to have occurred on the date stated above, at 4 P. m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiac Failure	11-5-44
Cardiac dilitation	

Other contributory causes of importance:

Arterio Sclerosis

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur?
(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Howard F. McArron M. D.

(Address) 2601 Garrison Blvd
Balto Md

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

G22333

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 183a

G22333
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1029 S. Sharp St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 1
(e) Length of stay in Baltimore (yrs., mos., or days) 18 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1029 S Sharp St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Melvin E. Sitney
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex Female
5. Color or race Col
6 (a) Single, married, widowed, or divorced. Widow
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 1894
8. AGE: Years 50 Months Days If less than one day hr. min.
9. Birthplace Va (Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name John Newby
13. Birthplace Va

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Raymond Sitney
(b) Address 1029 S Sharp
17 (a) Burial (b) Date thereof Nov. 9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Grove
Location Virginia
18 (a) Funeral director James A Stayer
(b) Address 142 W Steel St
19 (a)
(Date rec'd by registrar) Washington Boulevard Registrar

NOV 7 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/44 19 at 1 P. M.
21. I certify that death occurred on the date above stated, that I attended deceased from 11/3 1944 to 11/4 1944 and that I last saw h alive on 19
Immediate cause of death Cerebral Hemorrhage — Duration
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation None
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. C. Wilcox M. D.
Address 1135 Hanlon Date signed 11/4/44

G22334

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22334

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4516 Harford Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore city
(c) City or town (If outside city or town limits, write RURAL and give town)
(d) Street No. 4516 Harford Rd. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME WILLIAM J SAWYER

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M.	W	Widower

6 (b) Name of husband or wife Lillie MacKee
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar-13-1869

8. AGE: Years	Months	Days	If less than one day
75	7	21	hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name William J Sawyer
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Vanberg
15. Birthplace

16 (a) Informant Mrs Elizabeth Sawyer
(b) Address 4516 Harford Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-7-44 (month) (day) (year)
(c) Cemetery or crematory Western Cem
Location

18 (a) Funeral director L. J. Bruch
(b) Address 5205 Harford Rd

NOV 7 1944 (Date received by registrar) (b) Huntington Williams Mgr.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 4th 1944, at 3-15 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1939, to Nov 4 1944 and that I last saw him alive on Nov 2 1944.

Immediate cause of death Coronary Occlusion — Duration 10 Months
Due to
Due to
Other Conditions General Arteriosclerosis — 6 years
(Include pregnancy within 3 months of death)
Date of operation none
Major findings of operation: none
of autopsy: no

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide no
(b) Date of occurrence none at M
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury none
23. Signature L. J. Bruch M.D.
Address 5106 Harford Rd Date signed 11-6-44

G22335

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22335 Registered No. 4612

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 403 Whitridge (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME EMORY ~~Edward~~ Norris

3 (b) If veteran, name war

3 (c) Social Security Account No.

4, Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	MARRIED

6 (b) Name of husband or wife ANNA NORRIS
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAR. 10-1905

8. AGE: Years	Months	Days	If less than one day
39 ~~38~~	7	25	hr. min.

9. Birthplace BALTIMORE MD (Town, county, and state)
10. Usual Occupation CRANE OPERATOR
11. Industry or business BALTIMORE CITY

FATHER
12. Name EMORY NORRIS
13. Birthplace BALTIMORE MD

MOTHER
14. Maiden Name FLORENCE LOCKINGHAM
15. Birthplace BALTIMORE MD

16 (a) Informant RUSSELL NORRIS
(b) Address 349 MARYDELL AVE

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof NOV. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory BALTIMORE
Location BALTIMORE MD

18 (a) Funeral director Ulrich Funeral Home
Address 2[illegible] E. Oliver St

NOV 7-1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1944, at 4:40 A.M.

21. I certify that I took charge of the remains described above, held an Inquiry thereon and from the evidence obtained Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Carcinoma Stomach

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McCarthy M.D. Medical Examiner.
Date signed 11/5/44

G22336
TN. 90425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22336
Registered No. 122a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 days
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 211 N. Maderia St
(If rural give location)
(e) Citizen of foreign country? Madeira (Yes or No)
If yes, name country

3 (a) FULL NAME John Heise

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Anna (D
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15, 1871

8. AGE: Years	Months	Days	If less than one day
73	1	19	hr. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual Occupation
11. Industry or business

FATHER
12. Name Charles (D
13. Birthplace Germany

MOTHER
14. Maiden Name Elizabeth Snyder (D
15. Birthplace Germany

16 (a) Informant Baltimore City Hospitals
(b) Address 4940 Eastern Ave (Records

17 (a) Burial (b) Date thereof Nov 7th
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Baltimore Cem
Location City

18 (a) Funeral director Ullrich Funeral Home
(b) Address 2004-6 Orleans St

7 (a) 1944 Huntington Williams, M.D.
(Filed by registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1944, at 11:45 A.M. M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1944 to 11-4 1944, and that I last saw him alive on 11-4 1944

Immediate cause of death Cardiac Failure ; Duration

Due to Generalized Arterio-Sclerosis

Due to

Other Conditions Marasmus incarcerated ventral hernia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: None

of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H Keitler M. D.
Address Bell City Hosp Date signed 11-6-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

NOV 7

G22337

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 61

G22337 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N. Caroline St
(c) Hospital or institution: St Joseph's Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto.
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2002 E. Jefferson St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Hahn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	M.

6 (b) Name of husband or wife Geo J Hahn
6 (c) If alive, give age 57 years

7. Birth date of deceased (mo., day, yr.) Aug 11 - 1887

8. AGE: Years	Months	Days	If less than one day
57	2	25	..... hr. ..... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation
11. Industry or business At home

FATHER
12. Name Henry B. DeHuff.
13. Birthplace Baltimore

MOTHER
14. Maiden Name Elizabeth Wagner
15. Birthplace Pa

16 (a) Informant Geo J Hahn
(b) Address 2002 Jefferson St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer Cem
Location City

18 (a) Funeral director Welsh Funeral Home
(b) Address 2004 E. Orleans St

19 (a) ..... (b) ..... (Date rec'd by registrar) Registrar

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-1944, at 2:15 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1944, to 11-5 1944, and that I last saw her alive on 11-5 1944.

Immediate cause of death Cardiac Failure — Duration .....

Due to arteriosclerotic Cardio-vascular disease — Duration .....

Due to ..... — Duration .....

Other Conditions Diabetes — Duration .....

(Include pregnancy within 3 months of death)

Date of operation .....

Major findings of operation: .....

of autopsy: ✓

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? ..... (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ..... While at work? ..... (Specify type of place)
(e) Means of injury .....

23. Signature M E Robertson M. D.
Address St. Joseph's Hosp. Date signed 11-6-44

G22338

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22338 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1816 Ruxton Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1816 Ruxton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Abraham Fine

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Widower

6 (b) Name of husband or wife Late Daisy

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1868

8. AGE: Years 76 | Months | Days | If less than one day hr. min.

9. Birthplace Russia
(Town, county, and state)

10. Usual Occupation

11. Industry or business Retired

FATHER
12. Name Aaron Fine
13. Birthplace Russia

MOTHER
14. Maiden Name Unkown
15. Birthplace Russia

16 (a). Informant Marx Fine
(b) Address 1816 Ruxton Ave

17 (a) Burial (b) Date thereof Nov. 7, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 - 1126 W North Ave

19 (a) NOV 7 1944 Huntington Williams M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1944 at 6 P M

21. I certify that death occurred on the date above stated; that I attended deceased from July 1944 to Nov. 6 1944 and that I last saw h[illegible] alive on Nov. 6 1944.

Immediate cause of death Acute cardiac dilitation — Duration

Myocarditis

Due to Arteriosclerosis

Due to

Other Conditions Cataracts.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. Feldstein

Address 3214 - W North Ave. Date signed 11/9/44 M.D.

VS 190

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22339

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

105

G22339 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item o information should be carefully supplied. The exact age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13
(e) Length of stay in Baltimore (yrs., mos., or days) 53 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1727 Gwynns Falls Parkway (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Fannie Sopher

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Late Joseph
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1879

8. AGE: Years 65 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation
11. Industry or business House Work

MOTHER / FATHER
12. Name Abraham Berkowitz
13. Birthplace Russia
14. Maiden Name Matilda Caplan
15. Birthplace Russia

16 (a) Informant Morris Sopher
(b) Address 2520 Linden Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov, 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Bnai Israel Cemetery
Location Southern Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave
(c) (Date received by registrar) NOV 7 1944 Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1944 at 8:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to Nov 6 1944, and that I last saw her alive on Nov 6 1944

Immediate cause of death Cardio-Resp. failure — Duration

Due to Post-operative failure — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 11/6/44

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature S. Levinson
Address Sinai Hosp Date signed 11/6/44 M. D.

G22340

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22340 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 506 N. Lakewood Ave.
(c) Hospital or institution:
Home
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 55 Yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 506 N. Lakewood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME FRANK J. HARTKA

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	W

6 (b) Name of husband or wife Anna
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
75			hr. min.

9. Birthplace Germany (Town, county, and state)
10. Usual Occupation Engineer
11. Industry or business

FATHER
12. Name Jan
13. Birthplace Germany

MOTHER
14. Maiden Name Joanna
15. Birthplace Germany

16 (a) Informant Francis Buchacz
(b) Address 506 N. Lakewood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory St. Stanislaus
Location Dundalk Avenue

18 (a) Funeral director John J. DUDA
(b) Address 2829 Hudson Street

19 (a) 1944 (Filed by registrar) Huntington Williams M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/5 1944 at 5:30 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from 11/1 1944 to 11/5 1944
and that I last saw h[illegible] alive on 11/5 1944

Immediate cause of death Coronary Occlusion — Duration 1 Day
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Mr. Stanley T. Kwiatkowski
Address 1076 S. East Ave Date signed 11/6/44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

336757 G22341

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH ✓6

G22341
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadway
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 hrs.
(e) Length of stay in Baltimore (yrs., mos., or days) resident

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2427 Fleet St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Edward Regulski ✓

3 (b) If veteran, name war
3 (c) Social Security Account No. 217-22-3217

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12-1927

8. AGE: Years 17 | Months 9 | Days 24 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business Crown Cork & Seal Co

FATHER
12. Name George Regulski
13. Birthplace Md.

MOTHER
14. Maiden Name Stella Chrzanowski
15. Birthplace Poland

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL 11-9-44.

17 (a) Burial (b) Date thereof (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory St Stanislaus
Location Baltimore Md

18 (a) Funeral director George A. Weber
(b) Address 705 S Ann st

(a) (b)
(Date received by registrar) Huntington Williams, M.D.

NOV 7 1944

VS 130

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1944 6 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1944 to Nov. 6 1944 and that I last saw him alive on Nov. 6 1944

Immediate cause of death Meningo coccal meningitis (Respiratory failure)

Duration 36 hrs.

Due to Cerebro spinal Meningitis

IN hosp. 3 hrs.

Due to meningococci

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Graham A. Vance
Address Johns Hopkins Date signed 11/9/44

G22342

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22342 Registered No. 186a

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: Baltimore City Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 6 mos

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 18 N. Dallas Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry Short

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Colored	Single

6 (b) Name of husband or wife

6 (c) If alive, give age 1884 years

7. Birth date of deceased (mo., day, yr.) Feb 9, 1899

8. AGE: Years	Months	Days	If less than one day
55	8	27	hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Wm Short
13. Birthplace W. Va.

MOTHER
14. Maiden Name Anna Thomas
15. Birthplace W. Va.

16 (a) Informant Bon Secours Hospital Records
(b) Address

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof Nov 7/44 (month) (day) (year)

(c) Cemetery or crematory
Location Shenandoah Junction W. Va.

18 (a) Funeral director Mrs. Robert A. Elliott Dept
(b) Address 1129 N. Caroline St

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

NOV 7 - 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1944, at 9:40 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Fracture of cervical vertebra

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury November 2 1944 at M.
(b) Where did injury occur? 18 N. Dallas Street
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Fell down the stairs.

23. Signature H. J. Williams M.D.
Medical Examiner.
Date signed November 8, 1944.

G22343

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22343 Registered No. 1312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1235 Argyle Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1235 Argyle (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marie R. Browne

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: Wallace

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 1863

8. AGE: Years	Months	Days	If less than one day
81	7	17	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant Lillie May Adams
(b) Address 1235 Argyle Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary Cem.
Location A. G. County Md.

18 (a) Funeral director Mrs. Robert A. Ellis Undt.
(b) Address 1128 N. Carrollton St.

19 (a) 7 11 1944 (b)
(Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 · 4 1944, at 10:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1943, to 11 · 4 · 1944, and that I last saw h— alive on 11 · 4 · 1944.

Immediate cause of death	Duration
Pulmonary edema	2 days
Due to Chronic nephritis	12 mos.
Due to Chronic myocarditis	12 mos.
Due to	
Other Conditions Cerebral apoplexy	14 mos.

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Wm. L. Lay Berry M. D.
Address 1420 E. Chase Date signed 11-7-44

G22344

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

G22344 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Data correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4311 Kenwood Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME John A. Brown

3 (b) If veteran, name war

3 (c) Social Security Account No. 214-22-5979

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Frieda Frei Brown
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1, 1904

8. AGE: Years	Months	Days	If less than one day
40	8	5	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Assembly Man
11. Industry or business Glenn L. Martin Co.

FATHER
12. Name Ross P. Brown
13. Birthplace Balto. Co., Md.

MOTHER
14. Maiden Name Katie Reichert
15. Birthplace Balto., Md.

16 (a) Informant Mrs. J. A. Brown
(b) Address 4309 Kenwood Ave.

17 (a) burial (b) Date thereof Nov. 10, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Balto., Md.

18 (a) Funeral director Loeacher Funeral Home
(b) Address 7401 Belair Road

NOV 7 - 1944
(a) (Date rec'd by registrar) (b) Huntington Williams Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1944, at P. 2:25 A. M

21. I certify that I took charge of the remains described above, held an Inquiry and Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Occlusion.

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature H. Leo Lemmon M.D.
Medical Examiner.
Date signed November 6 1944

VS 151

G22345

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 92 B

G22345 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1104 WASHINGTON BOULEVARD
(c) Hospital or institution: NONE
(d) Length of stay in hospital or inst. (yrs., mos., or days) NO
(e) Length of stay in Baltimore (yrs., mos., or days) 83 YEARS

2. USUAL RESIDENCE OF DECEASED:
(a) State MARYLAND (b) County
(c) City or town CITY OF BALTIMORE.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1104 WASHINGTON BOULEVARD
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country:

3 (a) FULL NAME SUSAN TIERNEY.

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr 8th 1861.

8. AGE: Years 83. | Months 6 | Days 28,27 | If less than one day hr. min.

9. Birthplace S. Carolina (Town, county, and state)

10. Usual Occupation housework

11. Industry or business at home

FATHER 12. Name William Platt
13. Birthplace S. Carolina

MOTHER 14. Maiden Name Unknown
15. Birthplace "

16 (a) Informant Mrs Lillie English
(b) Address 1104 Washington Blvd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory New Cathedral Cem.
Location 4300 Old Frederick Rd.

18 (a) Funeral director John J Kenny For
(b) Address 1101-03 Gallows St.

NOV 7 1944 (Date received by Registrar) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION P

20. DATE OF DEATH NOVEMBER 5 1944 at 10.20 M

21. I certify that death occurred on the date above stated; that I attended deceased from MAY 16 1941 to NOV 5 1944.
and that I last saw her alive on NOV 5 1944.

Immediate cause of death	Duration
CHRONIC MYOCARDITIS MAY 16	1941
CHRONIC MITRAL REGURGATION	1941
Due to	
ARTERIOR SCLEROSIS	1941
Due to	
Other Conditions NONE	

(Include pregnancy within 3 months of death)
Date of operation NONE
Major findings of operation: NONE
of autopsy: NONE

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify about place)
(e) Means of injury

23. Signature Edward C. Blantier M. D.
Address 3013 ST PAUL STREET Date signed 11/6/4

G22346

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22346 Registered No. 1358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Greene Sts
(c) Hospital or institution:
University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore City
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 917 N. Carey St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Cody Thomas

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	C	Married

6 (b) Name of husband or wife Mrs Coley Thomas
6 (c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) June 1924

8. AGE: Years	Months	Days	If less than one day
20	5		hr. min.

9. Birthplace Nuttsville, Va (City or county, and state)
10. Usual Occupation Porter
11. Industry or business

FATHER
12. Name Henry Thomas
13. Birthplace Nuttsville, Va

MOTHER
14. Maiden Name Fannie Jordan
15. Birthplace Nuttsville, Va

16 (a) Informant Morell Thomas
(b) Address 917 N. Carey St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 6, 1944 (month) (day) (year)
(c) Cemetery or crematory
Location Nuttsville, Va

18 (a) Funeral director Wm. H. Holland
(b) Address 1631 Druid Hill Ave.

NOV 7 1944 (Date received by registrar) (b) Registrar

VS 160

Huntington-Williams, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4, 1944 at 11:35 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 1 1944 to Nov 4 1944, and that I last saw h[illegible] alive on Nov 4 1944.

Immediate cause of death Peripheral Vascular Collapse — Duration 4 days
Due to Hemorrhage
Due to Acute myocardium Ischemia
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation Nov. 2, 1944
Major findings of operation: Distended bladder - cystotomy
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence No at - M
(c) Where did injury occur? — (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — (Specify type of place) While at work? —
(e) Means of injury —
23. Signature Claude C. Cottet
Address University Hosp. Date signed Nov. 4, 44 M. D.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22347

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

80B

G22347 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Wyman Park Drive & 31st St.
(c) Hospital or institution: U. S. Marine Hospital
Since Oct. 25, 1944 4:00 PM
(d) Length of stay in hospital or inst. (yrs., mos., or days) Since Oct. 25, 1944
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Iceland (b) County
(c) City or town Reykjavik
(If outside city or town limits, write RURAL and give town)
(d) Street No. Hverfisgatu 102B (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME GRIMUR EINARSSON

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 13, 1917

8. AGE: Years	Months	Days	If less than one day
27	1	18	hr. min.

9. Birthplace Nedri-Dalur, Arnessysla, Iceland
(Town, county, and state)
10. Usual Occupation Carpenter
11. Industry or business -

FATHER
12. Name Einar ---
13. Birthplace Iceland

MOTHER
14. Maiden Name Unknown
15. Birthplace Iceland

16 (a) Informant Records, U.S. Marine Hospital
(b) Address Baltimore, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Mount

18 (a) Funeral director A. Lee Ader
(b) Address 4644 York Rd.

19 (a) NOV 7 1944 d by registrar Huntington Williams, M.D.

VS 184

56359

MEDICAL CERTIFICATION A.

20. DATE OF DEATH Oct. 31, 1944, at 1:05 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25, 1944 to Oct. 31, 1944, and that I last saw him alive on Oct. 31, 1944

Immediate cause of death	Duration
Encephalitis	Unk.
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation:
of autopsy: None done

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature M. D.
Address Baltimore, Md. Date signed 10/31/44

G22348 BALTIMORE CITY HEALTH DEPARTMENT G22348

CERTIFICATE OF DEATH 164a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Every correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Md.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2908 Sylvan Avenue (If rural give location)
(e) Citizen of foreign country? Baltimore (Yes or No)
If yes, name country

3. (a) FULL NAME Robert C. Lemmon

3 (b) If veteran, name war

3 (c) Social Security Account No. 213-05-6801

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lillian L. Lemmon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-18-1900

8. AGE: Years 44 | Months 7 | Days 17 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Stock Clerk.

11. Industry or business Forman Elec Co.

FATHER
12. Name Robert C. Lemmon
13. Birthplace Md

MOTHER
14. Maiden Name Mary Myers
15. Birthplace Md

16 (a) Informant Lillian L. Lemmon
(b) Address 2908 Sylvan Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-44 (month) (day) (year)
(c) Cemetery or crematory Baltimore
Location E North Ave.

18 (a) Funeral director Kendall E. Humphreys
(b) Address 1501 N. Broadway

19 (a) Date received NOV 7 1944 (b) Registrar Huntington Williams

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1944, at 7:10 P.M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Suicide. Hanging by Rope
Due to Mental Despondency.

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-5-44 at 6 P.M.
(b) Where did injury occur? 2908 Sylvan Ave (cellar)
(c) Did injury occur at home, on farm, industrial place, in public place? Home. While at work? No.
(d) Means of injury Hung himself in cellar.

23. Signature H. J. Wallenmeyer M.D. Medical Examiner.
Date signed November 6, 1944.

G22349

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 193a

G22349 Registered No.

1. PLACE OF DEATH: Baltimore, Md
(a) Baltimore City, Maryland
(b) Street address 478 Mansel Court
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 823 Pierce St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ino. A. Sullivan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male

5. Color or race: Colored

6 (a) Single, married, widowed, or divorced: widower

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 5 1889

8. AGE: Years 54 | Months 10 | Days 28 | If less than one day hr. min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Caleb Williams
13. Birthplace Md

MOTHER
14. Maiden Name Eliza Gregory
15. Birthplace Elizabeth City N C

16 (a) Informant Mamie G. Sullivan
(b) Address 478 Mansel Court

17 (a) Burial (b) Date thereof November 7, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) Filed 1944 (b) by registrar Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-3 1944 at 6 15 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-30 1944 to 11-3 1944, and that I last saw h alive on 11-2- 1944.

Immediate cause of death Acute Myocarditis

Due to

Due to

Other Conditions
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration: 5 days

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher M. D.
Address 1715 Pierce St Date signed 11-4-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22350 Li 2456 BALTIMORE CITY HEALTH DEPARTMENT 107 G22350
Registered No. (Col)

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1315 Hollins St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 19
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1315 Hollins St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Rose Elaine Lee Dorsey

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex Female
5. Color or race White
6 (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 2. 1944

8. AGE: Years | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name Charles Dorsey.
13. Birthplace Md

MOTHER
14. Maiden Name Rachel M. Moore
15. Birthplace Md

16 (a) Informant Charles J. Dorsey
(b) Address 1315 Hollins St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory Johnson Md
Location Hebron Jones Md

18 (a) Funeral director Wilkerson & Son
(b) Address 1217 St Paul St

19 (a) (b)
(Date received by registrar) Registrar

NOV 7 - 1944 Huntington Williams, MD

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944 at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1944 to Nov 7 1944 and that I last saw h w alive on 11/7 1944

Immediate cause of death Bronchopneumonia — Duration 2 days
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Chas A Carlson M. D.
Address 2145 W Belle Date signed 11/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.
MARGIN RESERVED FOR BINDING

G22351

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

√46B

G22351

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be careful correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 818 W. Fair mount
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 9d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 818 W. Fair mount (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Eugene Queen

3 (b) If veteran, name war

3 (c) Social Security Account No. 219-03-4308

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Margaret Queen

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 10 1904

8. AGE: Years 40 ~~75~~ Months 3 Days 24 If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)

10. Usual Occupation Work

11. Industry or business

FATHER 12. Name Arthur Queen
13. Birthplace Balto. Md.

MOTHER 14. Maiden Name Agnes Lee
15. Birthplace Balto. Md.

16 (a) Informant Mabel Mc Donald
(b) Address 818 W. Fairmount

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director Mrs. Katie R. Williams
(b) Address 322 N. Schroeder St

(a) NOV 7 - 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4 1944, at 9:00 P.M.

21. I certify that I took charge of the remains described above, held an Inquiry Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to Natural death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Carcinoma Stomach

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Eugene B. Mitchell Medical Examiner.
Date signed 11/4/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

22352

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22352 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga St.
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 38 min.
(e) Length of stay in Baltimore (yrs., mos., or days) 38 min

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Balto.
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4004 Fleetwood Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl DeRuggiero

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	S

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 11-6-44

8. AGE: Years	Months	Days	If less than one day
			hr. 38 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Victor DeRuggiero
13. Birthplace Naples, Italy

MOTHER
14. Maiden Name Mary Ruggiero.
15. Birthplace N.Y. U.S.A.

16 (a) Informant Mary DeRuggiero
(b) Address 4004 Fleetwood Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Cathedral
Location Balto Md

18 (a) Funeral director Guy C. Fyler
(b) Address Sutton & Fayette
NOV 8 - 1944 (b) Huntingdon Williams, Md.
(Date rec'd by local registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6- 1944, at 1 20 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-6 1944 to 11-6 1944 and that I last saw h[illegible] alive on 11-6 1944.

Immediate cause of death atelectasis

Due to Premature,

Due to 26 Weeks.

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature T. R. Bagley M. D.
Address Mercy Hospital Date signed 11-6-44

G22353

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46B

Registered No. G22353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MAKE NO PENCIL MARKS IN SPACES RESERVED FOR BEARING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 708 Druid Hill Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 708 Druid Hill Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John J. Williams

3 (b) If veteran, name war: World War #1
3 (c) Social Security Account No.

4. Sex: Male
5. Color or race: Col
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Lillian Williams
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 49 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation Chauffeur
11. Industry or business

FATHER
12. Name Alfred Williams
13. Birthplace Md.

MOTHER
14. Maiden Name Nancy Henson
15. Birthplace Md.

16 (a) Informant Lillian Williams
(b) Address 708 Druid Hill Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory Balto. National
Location

18 (a) Funeral director Elroy O. Wilson
(b) Address 1000 Bloomsbury Ave

NOV 8 1944 Huntington Md. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/4/44 1944 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/44 19 11/4/44 and that I last saw h alive on 11/4/44 19

Immediate cause of death Coronary Occlusion
Due to
Due to
Other Conditions Hypertension
Date of operation (Include previous within 3 months of death)
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Helen Elkin M. D.
Address 924 Mordecai Ave Date 11/8/44

G22354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22354

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1702 Eutaw Place
(c) Hospital or institution:
14
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 3½ yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1702 Eutaw Place (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Fred S. Bock

3 (b) If veteran, name war

3 (c) Social Security Account No. 066-16-6448

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Charlotte

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1900

8. AGE: Years	Months	Days	If less than one day
44			hr. min.

9. Birthplace Poland (town, county, and state)

10. Usual Occupation Mechanical Engineer

11. Industry or business

FATHER: 12. Name unknown
13. Birthplace Poland

MOTHER: 14. Maiden Name unknown
15. Birthplace Poland

16 (a) Informant Mrs Charlotte Bock
(b) Address 1702 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-44 (month) (day) (year)
(c) Cemetery or crematory Balto. Hebrew
Location

18 (a) Funeral director Jos Levin Inc
(b) Address 1439 E. Balto. St

19 NOV 8 - 1944 (Date received by Registrar) Huntington Williams, M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5- 1944, at 11:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 5-7- 1943, to 10-31- 1944 and that I last saw him alive on 10-31- 1944

Immediate cause of death	Duration
Heart failure	
Due to coronary occlusion	
Due to angina pectoris	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A. Weinberger M. D.
Address 912 Brookes Lane Date signed 11/6/44

G22355

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G22355

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 800 N. Port Street
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 800 N. Port Street (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James J. Marousek

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	widowed

6 (b) Name of [redacted] or wife Anna (nee Belsky)
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 28, 1878

8. AGE: Years	Months	Days	If less than one day
66	6	6	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation City Employee
11. Industry or business

FATHER
12. Name James Marousek
13. Birthplace Czech.

MOTHER
14. Maiden Name Unknown
15. Birthplace Czech.

16 (a) Informant Hilda Shank (daughter)
(b) Address 800 N. Port Street

17 (a) Burial (b) Date thereof 11/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or [redacted] Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Charles E. Schimunek
(b) Address 2601 E. Madison Street

NOV 8 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 19 44 at M

21. I certify that death occurred on the date above stated; that I attended deceased from November 1944 to Nov 4 1944 and that I last saw h[redacted] alive on Nov 4 1944

Immediate cause of death
Acute Cardiac Collapse — Duration 11/3/44
Due to Lobar Pneumonia — 10/20/44
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wilbur R. Boucot, M.D.
Address 801 N. Kenwood Ave. Date signed 11/8/44

G22356

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22356

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2608 Park Heights Terrace
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 36 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2608 Park Heights Terrace
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Isaac Dawn Feit

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Anna

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1892

8. AGE: Years 52 | Months | Days | If less than one day hr. min.

9. Birthplace Austria (Town, county and state)

10. Usual Occupation Upholstering

11. Industry or business

FATHER
12. Name Isaac Dawn Feit
13. Birthplace Austria

MOTHER
14. Maiden Name Mulley
15. Birthplace Austria

16 (a) Informant Anna Feit
(b) Address 2608 Pk. Hgts. Terrace

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-44 (month) (day) (year)
(c) Cemetery or crematory Rosedale
Location

18 (a) Funeral director Jack Levin Ind
(b) Address 1439 E. Balto. St

NOV 8 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Address 128 W. Lafayette Ave Balto. 17

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-5-44 19 at 11 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 19 44 to 11/5 19 44 and that I last saw h. alive on 11/5 19 44

Immediate cause of death Coronary Occlusion — Duration 7 hrs

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Huntington Williams, M.D. Date signed 11/6/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22357

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G22357 Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 309 Waxter St
(c) Hospital or institution: Warren Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days) 24

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 309 Waxter St. (If rural give location)
(e) Citizen of foreign country? Wales (Yes or No)
If yes, name country

3 (a) FULL NAME Walters. Huddleston

3 (b) If veteran, name war

3 (c) Social Security Account No. 235-07-4403

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Mable Huddleston

6 (c) If alive, give age 46 years

7. Birth date of deceased (mo., day, yr.) 12/23/1894 | 1894

8. AGE: Years 49 | Months 10 | Days 8 | If less than one day hr. min.

9. Birthplace W. Va. (Town, county, and state)

10. Usual Occupation Mine Foreman

11. Industry or business

FATHER
12. Name John Patty Huddleston
13. Birthplace W. Va.

MOTHER
14. Maiden Name Sallie Evans
15. Birthplace Va.

16 (a) Informant J. C. Huddleston
(b) Address Cedar Grove, W. Va.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)

(c) Cemetery or crematory Montgomery Mem. Pk Charleston W. Va.
Location Montgomery Charleston W. Va.

18 (a) Funeral director Hoge & Kenney
(b) Address Gallipolis Ferry

19 (a) NOV 8 - 1944 (Date rec'd by registrar) Thurlington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/1 1944, at 7:45 PM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH
Lobar Pneumonia

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. Michaelby M.D. Medical Examiner.
Date signed 11/2/44

(OVER)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G22358

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93

Registered No. G22358

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1838 W. Fayette St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days) 5 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1838 W. Fayette St.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George A. Mitchell.

3 (b) If veteran, name war

3 (c) Social Security Account No. 131-09-2457

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married.

6 (b) Name of husband or wife: Bessie Mitchell.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July-15-1888

8. AGE: Years 56 | Months 3 | Days 22 | If less than one day: hr. min.

9. Birthplace: Sparta - Greece.
(Town, county, and state)

10. Usual Occupation: Restaurant -

11. Industry or business: - Business.

FATHER
12. Name: Arthur Mitchell.
13. Birthplace: Greece.

MOTHER
14. Maiden Name: Mary Lines.
15. Birthplace: Greece.

16 (a) Informant: Mr. P.A. Mitchell.
(b) Address: Laurens - S.C.

17 (a) Removal (b) Date thereof: Nov. 7-44.
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory: Forest Lawn Cem.
Location: Laurens - S.C.

18 (a) Funeral director: Charles J. Schwab.
(b) Address: 505 N. Monroe St.

Date received: NOV 8 1944 (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 7th; 1944 at 3 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944 to Nov 7 1944 and that I last saw him alive on Nov 6 1944

Immediate cause of death: Chronic myocarditis

Due to:

Due to:

Other Conditions: Cardiac asthma.

(Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:

23. Signature: Albert Seagroth M. D.

Address: 124 W Lowndes Date signed 11/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

22359

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered 22359

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 847 W Lombard St.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 847 W Lombard St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Khimas (Khemens)

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-09-5966

4. Sex MALE | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Yvonne

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years 60 | Months | Days | If less than one day hr. min.

9. Birthplace Lith. (Town, county, and state)

10. Usual Occupation labor

11. Industry or business

FATHER
12. Name ?
13. Birthplace Lith.

MOTHER
14. Maiden Name ?
15. Birthplace Lith.

16 (a) Informant Mary Rollison
(b) Address 847 W Lombard St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 8-44 (month) (day) (year)

(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director Joseph Kaminskas Sons
(b) Address 602 E Washington Blvd

NOV 8 - 1944 (Date received by registrar)

(b) Huntington Williams Mgr.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1944, at 2 a M

21. I certify that death occurred on the date above stated; that I attended deceased from October 26 1944, to Nov. 4 1944, and that I last saw h. alive on Nov 3 1944.

Immediate cause of death Coronary Thrombosis — Duration 5 Min.
Due to arteriosclerosis
Due to
Other Conditions Chronic Myocarditis
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

3 Nov

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature Elizabeth Mortimer Jr. M. D.
Address 2706 St Paul St Date signed 11/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully considered and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G22360

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

93D

Registered No. G22360

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2211 Rogues Ave
(c) Hospital or institution: Home for the Aged & Infirm Colored Females
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2211 Rogues Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Grace Elma Ahler

3 (b) If veteran, name war: N

3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 12 1873

8. AGE: Years 71 | Months 9 | Days 23 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name John Ryan Ahler
13. Birthplace Md

MOTHER
14. Maiden Name Eliza J. Hamilton
15. Birthplace Balto Md

16 (a) Informant Miriam J Cooke
(b) Address 2211 Rogues Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Wilkens Colored
(b) Address 1214 St Paul Thurlow or Williams, Undr.

19 (a) NOV 8 - 1944 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1944 at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1944 to Nov 5 1944 and that I last saw h[illegible] alive on Nov 5 1944

Immediate cause of death: Myocardial Insufficiency — Duration: 10 days
Due to: Arteriosclerosis — 10 yrs.
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Arthur J Davis M. D.
Address 800 N Eutaw Date signed 11-6-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Give the cause of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

VS 150

G22361 BALTIMORE CITY HEALTH DEPARTMENT G22361

CERTIFICATE OF DEATH 94a

Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly. RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2701 Fenwick Ave
(c) Hospital or institution:
9 b
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2701 Fenwick Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs. Geo. W. Morey (George W. Morey)

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5541

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Lillie M. Morey
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 6 1876

8. AGE: Years	Months	Days	If less than one day
68	10	0	hr. min.

9. Birthplace Balto. Md. (Town, county, and state)
10. Usual Occupation Stationary Engineer
11. Industry or business Federal Housing Commission

MOTHER / FATHER
12. Name George W. Morey
13. Birthplace Unknown
14. Maiden Name Frances Hannah Barker
15. Birthplace Unknown

16 (a) Informant Mrs. Lillie M. Morey
(b) Address 2701 Fenwick Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn Md

18 (a) Funeral director Milford E. Lee
(b) Address 529 E. Fayette St

NOV 8 1944 (Date rec'd by Registrar) (b) Huntington Williams M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1944, at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2 1944, to Nov 6 1944 and that I last saw him alive on Nov 6 1944.

Important causes of death	Duration
Coronary Thrombosis	9 Days
Due to Angina Pectoris	4 Yrs
Due to Arteriosclerotic Cardiovascular Degeneration	6 Yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. Zimmerman M.D.
Address 2550 Hanover Date signed 11/7/44

G22362

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 117a

Registered No. G22362

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2507 Edmondson Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2507 Harlem Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Elizabeth S. Pancoast

3 (b) If veteran, name war	3 (c) Social Security Account No.
W	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife George Pancoast
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 15 1868

8. AGE: Years	Months	Days	If less than one day
76	8	20	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation Home
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine Tutor
15. Birthplace Germany

16 (a) Informant Mrs Dorothy Waidner
(b) Address 2507 Harlem Ave

17 (a) Burial (b) Date thereof 11/8/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul st.

19 (Date rec'd by registrar) NOV 8 - 1944 Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1944, at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 30 1944 to Nov 5 1944, and that I last saw h[illegible] alive on Nov 5 1944.

Immediate cause of death (1) Coronary Thrombosis — Duration W-5 days
Sis. —(a) arteriosclerotic type
heart disease with congestive failure — 2 several years
Due to Generalized arteriosclerosis
Due to
Other Conditions Gastric ulcer
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H W Nuschel M. D.
Address 2901 Edmondson Ave Date signed Nov 7 44

VS 150

G22363

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

Registered No. G22363

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & 33rd sts.
(c) Hospital or institution:
Union Memorial
(d) Length of stay in hospital or inst. (yrs., mos., or days) 29 days
(e) Length of stay in Baltimore (yrs., mos., or days) 29 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore County
(c) City or town Middle River (If outside city or town limits, write RURAL and give town)
(d) Street No. 1608 Dolfield Rd. (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Girl Dolan. (Anne Holden Dolan)

3 (b) If veteran, name war: N

3 (c) Social Security Account No. none

4. Sex: F

5. Color or race: White

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-16-44

8. AGE: Years | Months | Days 1 | If less than one day: hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Capt. Frank Dwyer Dolan
13. Birthplace

MOTHER
14. Maiden Name Eileen Clark.
15. Birthplace New York

16 (a) Informant Capt Frank Dolan 2nd
(b) Address 46A Hewson Place Brooklyn N.Y.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory St. Johns
Location Queens Borough N.Y.

18 (a) Funeral director William Cook Inc.
(b) Address 217 W. Paul St.

19 NOV 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1944 at 10:35 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-16 1944 to 11-7 1944 and that I last saw her alive on 11-7 1944.

Immediate cause of death	Duration
(a) Cardio respiratory failure	
Due to (b) Premature birth	
Due to (c)	
Other Conditions Staph infection (Include pregnancy within 3 months of death)	

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Jack C. Morgan M. D.
Address U.M.H. Date signed 11-7-44

G22364

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G22364

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 817 N. Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 817 N. Saratoga St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Loretta Milbourne

3 (b) If veteran, name war —

3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Negro | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Charles

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 12 - 1904

8. AGE: Years 40 | Months 6 | Days 23 | If less than one day ____ hr. ____ min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden Name Unknown
15. Birthplace

16 (a) Informant Charles Milbourne
(b) Address 817 Saratoga St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8, 1944 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Md.

18 (a) Funeral director Mrs. Geo. A. Hollan
(b) Address 1631 Druid Hill Ave.

NOV 8 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 5 - 1944, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Inspection & Inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Carcinoma of Cervix Uteri

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Howard J. Brodsky M.D.
Medical Examiner.
Date signed 11-6-44

G22365

BALTIMORE CITY HEALTH DEPARTMENT

AB-90510

CERTIFICATE OF DEATH

§3a

Registered No. G22365

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1day
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1109 Laurens St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Monroe Tollen

3 (b) If veteran, name war

3 (c) Social Security Account No. 218-03-3785

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	Col.	married

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June ?-1897

8. AGE: Years	Months	Days	If less than one day
47	5	?	hr. min.

9. Birthplace ? N.C.
(Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name ? Everett Tollen
13. Birthplace ? N.C.

MOTHER
14. Maiden Name ? Julia
15. Birthplace ? N.C.

Unable to obtain further information

16 (a) Informant Records } Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (b) Date thereof 11-8-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location

18 (a) Funeral director A. Halstead
(b) Address 918 Druid Hill Ave.

NOV 8 - 1944 Huntington Williams M.D.
(Date received by registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4- 1944, at 5.40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/3 1944, to 11/4 1944, and that I last saw h[illegible] alive on 11/4 1944.

Immediate cause of death	Duration
Cerebral accident, probably throm. 4d?	
Due to basis of middle cerebral artery	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: no post

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature C. A. Perry, Jr. M.D.
Address City Hosp Date signed 11/5/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22366

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

Registered No. G22366

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2411 Linden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2411 Linden Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME ANNA NEULAND

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	--

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Single

6 (b) Name of husband or wife --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Apr. 18, 1862

8. AGE: Years	Months	Days	If less than one day
82	6	19	hr. min.

9. Birthplace Germany
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Christian Neuland
13. Birthplace Germany

MOTHER
14. Maiden Name Margarite ?
15. Birthplace Germany

16 (a) Informant Mr. Wm. G. Kanne, Friend
(b) Address 2411 Linden Ave.

17 (a) Cremation (b) Date thereof 11/9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Loudon Crematory
Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 8 - 1944 (b) Huntington Williams, M.D.
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1944, at 3:30 P M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 1944 to Nov 7 1944 and that I last saw h alive on June 6 1944

Immediate cause of death
Asphyxia Edema — Lobar Pneumonia — Duration 20 hr. 6 day
Due to
Due to
Other Conditions Hypertension
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Edward Barb M. D.
Address 1811 Gwynns Falls Date signed Nov 7 1944

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22367 ✓ G22367

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93E

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2803 Elsinore Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2803 Elsinore Avenue
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Miss Margaret Tickner (Margaret Diana Tickner)

3 (b) If veteran, name war: None
3 (c) Social Security Account No.: None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1881

8. AGE: Years 63 | Months 1 | Days 14 | If less than one day hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name William J. Tickner
13. Birthplace New York City, N. Y.

MOTHER
14. Maiden Name Margaret E. Cooper
15. Birthplace Sewells Point

16 (a) Informant Miss Mary V. Tickner
(b) Address 2803 Elsinor Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cem.
Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 21d NOV 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6, 1944, at 11:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Aug. 2 1944, to Nov. 6 1944, and that I last saw h. er alive on Nov. 5, 1944

Immediate cause of death: Cerebral Embolism — Duration: 5 min.
Due to: Myocarditis
Due to:
Other Conditions: Phlebitis — 3 months
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. A. Kupp M. D.
Address 3030 Edmondson Ave. Date signed 11/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Write the causes of death clearly and legibly. Physicians; please write correct age in especially important.

G22368

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

94a

Registered No. G22368

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert + Saratoga Sts
(c) Hospital or institution: Mercy Hospital - D.O.A.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Md (If outside city or town limits, write RURAL and give town)
(d) Street No. 233 Park Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Lusby

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	

6 (b) Name of husband or wife Sophia W. (Werner) 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 19, 1890

8. AGE: Years	Months	Days	If less than one day
54	1	18	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Waterdasher

11. Industry or business

FATHER
12. Name — Lusby
13. Birthplace Md

MOTHER
14. Maiden Name —
15. Birthplace Md

16 (a) Informant Mrs. Sophia W. Lusby
(b) Address 233 Park Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11.10.44 (month) (day) (year)
(c) Cemetery or crematory London Park
Location 3901 Frederick Rd

18 (a) Funeral director Harry A Wilke
(b) Address 4101 Edmondson Ave

NOV 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944, at 1:45 P M

21. I certify that I took charge of the remains described above, held an Investigation-Inquest thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Coronary Thrombosis

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work?
(d) Means of injury —

23. Signature Charles S. Lubman M.D. Medical Examiner.
Date signed 11/7/44

G22369

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

87c

Registered No. G22369

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 600 N. Hilton St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 16
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 600 N. Hilton St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Mary Ellen Andrews

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	W.	Married

6 (b) Name of husband or wife Charles R. W.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1872

8. AGE: Years	Months	Days	If less than one day
72	-	3	hr. min.

9. Birthplace Berlin, Md. (Town, county, and state)

10. Usual Occupation H. W.

11. Industry or business

MOTHER / FATHER

12. Name John J. Walker

13. Birthplace Berlin.

14. Maiden Name Elizabeth Ann Crocker

15. Birthplace Berlin, Md.

16 (a) Informant Geo. R. M. Andrews

(b) Address 600 N. Hilton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 8/44 (month) (day) (year)

(c) Cemetery or crematory Cedar Hill

Location A.A. Co. Md.

18 (a) Funeral director Harry H. Wiltsie

(b) Address 4101 Edmondson Ave

19 NOV 8 - 1944 (Date rec'd by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/6/44 19 , at 4 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 6 1944, to Nov 6 19 44 and that I last saw h e r alive on 11/6 19 44.

Immediate cause of death	Duration
Cerebral Edema	
Due to Arteriosclerosis	
Due to	
Other Conditions Paralysis Agitans	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. J. Klezek M.D.

Address 4710 Liberty Hts Date signed 11/7/44

G22370

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 467

Registered No. G22370

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33d & Calvert St.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 9 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1061 Temple Garden Apts. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Maxie B. Likes

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Sylvan S. Likes

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 8, 1878

8. AGE: Years 66 | Months 5 | Days 29 | If less than one day hr. min.

9. Birthplace Virginia (town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER 12. Name Isidore Siegbold

13. Birthplace England

MOTHER 14. Maiden Name Rachel Myers

15. Birthplace Virginia

16 (a) Informant Mrs. Philip Likes

(b) Address Temple Garden Apts

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)

(c) Cemetery or crematory Loudon Park

Location Balto. Md.

18 (a) Funeral director Harris Sonnheim & Son

(b) Address 2344 Eutaw Place

NOV 8 - 1944 (Date rec'd by registrar)

Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1944, at 6 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 8 1944, to Nov. 7 1944, and that I last saw her alive on Nov. 7 1944.

Immediate cause of death: Cardio respiratory failure

Due to: Post-operate lobular pneumonia

Due to: Carcinoma of the rectum

Other Conditions:

(Include pregnancy within 3 months of death)

Date of operation Nov. 2, 1944

Major findings of operation: Ca of rectum

of autopsy:

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Geo. W. Harrington Jr. M. D.

Address 33 E. University Pkwy Date signed 11/7/44

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G22371

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 937

Registered No. G22371

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St
(c) Hospital or institution: Sinai Hospt
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3408 Holmes Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lipsitz, Harry

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Ida

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1859

8. AGE: Years 85 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Louis
13. Birthplace Russia

MOTHER
14. Maiden Name Not Known
15. Birthplace Russia

16 (a) Informant Hosp Records
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-44 (month) (day) (year)
(c) Cemetery or crematory Southern Ave
Location Southern Ave

18 (a) Funeral director Jewish Funeral Dir
(b) Address 1439 E. Balto St

19 (a) Nov 8 1944 (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-6 1944, at 7:45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 11-1 1944, to 11-6 1944, and that I last saw him alive on 11-6 1944.

Immediate cause of death Cardio-respiratory failure — Duration

Due to Hypertensive and arteriosclerotic Heart disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Jerome P. Darkin M. D.
Address Sinai Hospital Date signed 11-6-44

VS 150

G22372

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 944a

Registered No. G22372

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1800 Madison St-Da*
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1800 Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Israel Wainglass

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No.:

4. Sex: M
5. Color or race: W.
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Annie
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years: 46 | Months | Days | If less than one day: hr. min.

9. Birthplace: Russia
(Town, county, and state)
10. Usual Occupation: Grocery Store
11. Industry or business

FATHER
12. Name: Jacob
13. Birthplace: Russia

MOTHER
14. Maiden Name: Pearl
15. Birthplace: Russia

16 (a) Informant: Husband
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-8-44 (month) (day) (year)
(c) Cemetery or crematory: Mt Carmel
Location: O'Donnell St

18 (a) Funeral director: Jack Lamblin
(b) Address: 1439 E. Baltimore St

19 NOV 8 - 1944 (Date rec'd by registrar) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944, at 10:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon, and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Coronary Thrombosis

Due to:

Other Conditions:
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury — at — A.M.
(b) Where did injury occur? —
(c) Did injury occur at home, on farm, industrial place, in public place? — While at work? —
(d) Means of injury —

23. Signature: Chester F. Lebkicher M.D.
Medical Examiner.
Date signed 11/7/44

VS 151

correct age is especially important. Physicians: please write the cause of death clearly and legibly.

G22373

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22373 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be sure to write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2020 W Saratoga St
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 20
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2020 W. Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mary Jane Quinn

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John E. Quinn

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar 18 1872

8. AGE: Years 72 | Months 7 6 | Days 19 | If less than one day hr. min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name John J Leakin
13. Birthplace Balto

MOTHER 14. Maiden Name Bridget ?
15. Birthplace Ireland

16 (a) Informant Mrs John C Buttner
(b) Address 202 W Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 17 1944 (month) (day) (year)

(c) Cemetery or crematory Cathedral
Location Baltimore

18 (a) Funeral director Rita Winfield
(b) Address 917 Greenmount Ave

19 (a) Filed NOV 8 1944 (b) Huntington Williams, Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/44 19 , at 11 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1 19 44 to 11/7 19 44 and that I last saw her alive on 11/7 19 44

Immediate cause of death Acute cardiac dilatation — Duration 2 hrs

Due to Chronic myocarditis — 2 yrs

Due to hypertension

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature A Cates M. D.
Address 4 W. Fulton Date signed 11/7/44

G22574

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22574 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1200 Valley St

(c) Hospital or institution: Home for the Aged

(d) Length of stay in hospital or inst. (yrs., mos., or days) 10

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (If outside city or town limits, write RURAL and give town)

(d) Street No. Same (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) FULL NAME Margaret Ryan

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife: William Ryan

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12 July 1871

8. AGE: Years 73 | Months 3 5 | Days 26 | If less than one day hr. min.

9. Birthplace Dublin Ireland (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Richard O'Ryan

13. Birthplace Ireland

MOTHER

14. Maiden Name Mary Griffette

15. Birthplace Ireland

16 (a) Informant Libby Lister of the Poor

(b) Address 1200 Valley St Baltimore

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof Nov. 9 1944 (month) (day) (year)

(c) Cemetery or crematory Calhudral

Location Baltimore.

18 (a) Funeral director Rita Wiedefeld

(b) Address 914 Gruenwald Home for Williamsport, Md.

19 (a) Hurting for Registrar

NOV 8 1944

VS 125

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov-8- 1944, at 12:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944, to Nov 8 1944, and that I last saw her alive on Nov 7 1944

Immediate cause of death	Duration
Acute Dilatation of Heart	1 day
Due to Chronic myocarditis	3 yr
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature C. Gill Hall M. D.

Address 1631 E North Ave Date signed

Partee

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

622375

PLACE OF DEATH:
Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:
JOHNS HOPKINS HOSPITAL

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 1006 N. Bond St
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Jesse D. Partee

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	Black	Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-7-07

8. AGE: Years	Months	Days	If less than one day
36	10	28	hr. min.

9. Birthplace N.C.
(Town, county, and state)

10. Usual Occupation Porter

11. Industry or business

FATHER
12. Name Charles Partee
13. Birthplace N.C.

MOTHER
14. Maiden Name Maggie ?
15. Birthplace S.C.

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov 8 1944
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Salisbury
Location North Carolina

18 (a) Funeral director Mrs Katie R. Williams
(b) Address 322 N Schroeder St

19 (a) (b)
Registered by registrar NOV 8 - 1944 Washington Williams, M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 19 44 M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 23 1944 to Nov 5 19 44 and that I last saw h[illegible] alive on Nov 5 19 44

Immediate cause of death: Uraemia — Duration: 3 weeks

Due to Arteriosclerotic nephrosclerosis

Due to Hypertensive cardiovascular renal disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)

(e) Means of injury

23. Signature Albert A. Kattus

Address John Hopkins Hosp Date signed 11/6/44
M D

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22376 BALTIMORE CITY HEALTH DEPARTMENT G22376
CERTIFICATE OF DEATH 93D Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 420 N. Bonaldin St
(c) Hospital or institution: 2nd

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 420 N. Bonaldin St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Harry L. Mc Elwee
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Married
6 (b) Name of husband or wife Catherine W. McElwee
6 (c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.) Sept-10-1875
8. AGE: Years 70 | Months 1 | Days 28 26 | If less than one day hr. min.
9. Birthplace Balto. Md.
(Town, county, and state)
10. Usual Occupation Unemployed
11. Industry or business

FATHER
12. Name William McElwee
13. Birthplace Chestertown, Md.

MOTHER
14. Maiden Name Mary Jane Owens
15. Birthplace Md.

16 (a) Informant Catherine W. Mc Elwee
(b) Address 420 N. Bonaldin St

17 (a) Burial (b) Date thereof 11 - 10 - 44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Eastern Ave.

18 (a) Funeral director Fahy & Miller Inc
(b) Address 2435 E. Pratt St

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, M.D.

VS 150 NOV 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH 11 - 6 - 1944 at 1130 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-4 1944 to 11-6 1944.
and that I last saw him alive on 11-6 1944.

Immediate cause of death	Duration
Coronary Occlusion	10 Minutes
Due to Chr. Myocarditis	?
Due to Cerebral arterio-sclerosis	?
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature N. J. Davidow M. D.
Address 3218 Eastern ave. Date signed 11-8-44

3137 G22377 BALTIMORE CITY HEALTH DEPARTMENT G22377
Registered No.

CERTIFICATE OF DEATH 48a

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1015 S Streeper St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Anna Stoney
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female
5. Color or race: white
6 (a) Single, married, widowed, or divorced: married
(b) Name of husband or wife: ?
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-8-07

8. AGE: Years	Months	Days	If less than one day
37	1	27	hr. min.

9. Birthplace Md (Town, county, and state)
10. Usual Occupation Housewife
11. Industry or business

FATHER
12. Name ?
13. Birthplace ?

MOTHER
14. Maiden Name Tillie Evans
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11-9-44 (Month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Road
18 (a) Funeral director Thos. A. Kelly Son
(b) Address 2435 E. Oliver St
19 (a) NOV 8 1944 Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 5 1944 at 8 15 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 12 1944 to Nov 1944, and that I last saw her alive on Nov. 5 1944.

Immediate cause of death	Duration
Cardiac failure	
Due to Uremia from ureteral obstruction	19 days
Due to Carcinoma of cervix uteri	?3 yrs
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: Not obtained.

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature David B. Cheek M.D. M. D.
Address Johns Hopkins Hosp. Date signed 11-5-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22378 G22378

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1141c

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Redwood & Green Sts.
(c) Hospital or institution:
Univ. Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15 d
(e) Length of stay in Baltimore (yrs., mos., or days) 22yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1934 N Durham (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country

3 (a) FULL NAME PAULINE FREDERICK REED RAUSCH

3 (b) If veteran, name war No.

3 (c) Social Security Account No. 213-12-8043

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Walter A Rausch

6 (c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Jan 11, 1922

8. AGE: Years 22 | Months 9 | Days 27 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Factory Worker

11. Industry or business Westinghouse Mfg. Co

FATHER 12. Name William A. Reed

13. Birthplace Georgia

MOTHER 14. Maiden Name Elizabeth Sullivan

15. Birthplace Baltimore, Md

16 (a) Informant Mr. Walter J. Rausch

(b) Address 1834 N Durham

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-44 (month) (day) (year)

(c) Cemetery or crematory New Cathedral Cem

Location Baltimore, Md

18 (a) Funeral director Henry Sander & Sons, Inc.

(b) Address North Ave. & Broadway

19 NOV 8 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1944 at 2:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from 10/23 1944 to 11/7 1944; and that I last saw her alive on 11/7 1944

Immediate cause of death Septicemia, Duration

Overwhelming Uremia

Due to endometritis

Due to ? spon. abortion

Other Conditions peritonitis, diffuse.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation: Gangrenous bowel.

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Ernest H. Kury M. D.

Address Date signed

VS 186

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Every correct age is especially important.

G22379

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 1937

G22379 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore, Maryland
(c) Hospital or institution: Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 Gough Street
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Buenger

3 (b) If veteran, name war No

3 (c) Social Security Account No. ?

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. ?, 1883

8. AGE: Years	Months	Days	If less than one day
61			hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual Occupation Watchman

11. Industry or business Ret. 1 yr.

FATHER
12. Name John Henry Buenger
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Christina Schauman
15. Birthplace Baltimore, Md

16 (a) Informant Miss Laura Buenger
(b) Address 1815 Gough Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Carmel Cemetery
Location Baltimore, Maryland

18 (a) Funeral director Henry Sander & Sons, Inc.
(b) Address North Ave. & Broadway

NOV 8 1944

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1944, at 10 M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Arteriosclerotic cardiovascular disease

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature W. Z. Wallenmeyer M.D. Medical Examiner.
Date signed November 6/1944.

G22380

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 150

G22380 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1213 Light St.
(c) Hospital or institution: South Baltimore General Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Woodlawn Md
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country (Yes or No)
If yes, name country West Indian Island

3 (a) FULL NAME Annie M. Anthony

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Colored	

6 (b) Name of husband or wife Eugene Anthony
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 16, 1899

8. AGE: Years	Months	Days	If less than one day
45	0	27	hr. min.

9. Birthplace West Indian Islands (Town, county, and state)
10. Usual Occupation Home Wife
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Eugene Anthony
(b) Address Woodlawn Md

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof November 8, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Lebanon
Location Baltimore County Md

18 (a) Funeral director Joseph G. Healy
(b) Address 4691 Mount Hope Huntington Williams Md.

NOV 8 1944 (Signature of local registrar)

VS 150

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1944 at 5-07 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 10 1944 to Nov 6 1944 and that I last saw h.e.r. alive on Nov. 6 1944.

Immediate cause of death Carcinoma of left breast with generalized metastasis — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation 7-31-44

Major findings of operations: Carcinoma of left breast

of autopsy Same as above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Paul H. Lucas M. D.

Address 1213 Light St. Date signed Nov 8, 1944

G22381

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

G22381
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2704 Huntingdon Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 17
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2704 Huntingdon Ave (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME William Stewart Fuller

3 (b) If veteran, name war	3 (c) Social Security Account No.
—	—

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Annie R. Fuller
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 5-1868

8. AGE: Years	Months	Days	If less than one day
76	—	21	hr. min.

9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation Paper Hanger
11. Industry or business

FATHER
12. Name George Fuller
13. Birthplace Maryland

MOTHER
14. Maiden name Ellen Alice Stewart
15. Birthplace Maryland

16 (a) Informant Mrs. Annie R. Royston
(b) Address 2704 Huntingdon Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9-1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Zion (Black Rock Road)
Location Baltimore Co. Md.

18 (a) Funeral director Burgee Funeral Home
(b) Address 3231 Falls Road

19 (a) (b)
Date Received NOV 8 1944 Registrar Huntington Williams, MD Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1944 at 8:30 a M

21. I certify that death occurred on the date above stated, that I attended deceased from Oct. 20 1943 to Nov 6 1944, and that I last saw h Gr alive on Nov 6 1944

Immediate cause of death	Duration
Chronic myocarditis	
Due to	
Due to	
Other Conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address 112 W. 20th Date signed Nov 6 44

G22382 KIRTILIS

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22382 Registered No. 1318

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd and Calvert Sts.
(c) Hospital or institution: Union Memorial Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore Darley PP (If outside city or town limits, write RURAL and give town)
(d) Street No. 800 ~~Darley~~ Street (If rural give location)
(e) Citizen of foreign country? Yes (Yes or No)
If yes, name country Greece

3 (a) FULL NAME Mr. Gus Kirtilis

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) ~~Single, married~~, widowed, or ~~divorced~~: Single

6 (b) Name of husband or wife: Eva M. Kirtilis
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 4 1900

8. AGE: Years 44 | Months 6 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace Greece (Town, county, and state)

10. Usual Occupation Lunch-room proprietor

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden Name Unknown
15. Birthplace Unknown

16 (a) Informant Benjamin H. Barnes.
(b) Address 3511 Elm Ave

17 (a) Cremation (Burial, cremation, or removal) (b) Date thereof Nov 9/44 (month) (day) (year)
(c) Cemetery or crematory Greenmount C.
Location

18 (a) Funeral director Chenault & Donovan
(b) Address 3415-17 Chestnut Ave

19 (a) Filed NOV 9 1944 Huntington Mills Registrar
VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/44 19 at 6.15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4/44 19 to 11/7/44 19, and that I last saw h[illegible] alive on 11/6/44 19.

Immediate cause of death	Duration
Cardio-respiratory Failure	
Due to Uremia	
Due to Chronic Glomerular Nephritis	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Geo. W. Binkley Jr. M.D.
Address 322 E. University Pkwy Date signed 11/7/44

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22383 1310 Reg. G22383

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~Chamber~~ Calvert & Saratoga
(c) Hospital or institution: Mercy Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 11
(e) Length of stay in Baltimore (yrs., mos., or days) 45 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. Charles St & Mt Vernon Pl. (If rural give location)
(e) Citizen of foreign country? ~~Yes~~ No (Yes or No)
If yes, name country

3 (a) FULL NAME Michael Pacienza
3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Deceased
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 10-9-1862

8. AGE: Years 82 | Months 0 | Days 29 | If less than one day — hr. — min.

9. Birthplace Italy (Town, county, and state)

10. Usual Occupation Retired

11. Industry or business —

FATHER
12. Name —
13. Birthplace —

MOTHER
14. Maiden Name —
15. Birthplace —

16 (a) Informant Dr Pacienza
(b) Address —

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory New Cath - Location Balto Md

18 (a) Funeral director F.V. Repetto
(b) Address 2818 E. Baltimore St.

19 (a) [illegible] (b) [illegible] Washington Williamsport Md
NOV 8 1944
VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8 1944 at 9:25 M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/6 1944 to 11/8 1944, and that I last saw him alive on 11/8 1944

Immediate cause of death: Respiratory Failure — Duration 2 Days
Due to: Hypertensive degenerative Cardio-renal-Vascular — 20 yrs
Due to: Disease —
Other Conditions —
(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at — M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury —

23. Signature Charles F. O'Donnell M.D.
Address Mercy Hosp Date signed 11/8/44

G22354

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22384
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1604 N. Bond Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) None
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County City
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1604 N. Bond Street
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME August Albert Frey

3 (b) If veteran, name war: World War I
3 (c) Social Security Account No. 216-09-0572

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife: Pauline Lurz
6 (c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Nov. 18, 1891

8. AGE: Years	Months	Days	If less than one day
52	11	20	#### min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual Occupation: Trucker
11. Industry or business: Printing Co.

FATHER
12. Name: August W. Frey
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden Name: Katie Young
15. Birthplace: Philadelphia Pa.

16 (a) Informant: Mrs. Pauline Frey
(b) Address: 1604 N. Bond Street

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory: Baltimore National
Location: Frederick Rd. Balto; Md.

18 (a) Funeral director: George J. Ruth, Inc.
(b) Address: 1735 Harlem Avenue

(a) Filed 1944 (b) [signature] (registrar) Washington Williams M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from August 15 1944 to Nov. 8 1944, and that I last saw h[illegible] alive on Nov. 7, 1944.

Immediate cause of death: Coronary Occlusion

Due to: Chr. Congestive Heart Failure

Due to: Coronary Condus - Vascular Disease

Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operations:
of autopsy:

Duration: 10 min. | 4 mos | 4 mos

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence: at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Earnest Lerr
Address: 160[illegible] N Broadway Date signed 11/8/44

Earnest Lerr

G22385

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 108

G22385 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 402 N. Caroline (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lillian Prince

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex Female | 5. Color or race Black | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-25-94

8. AGE: Years 50 | Months 7 | Days 9 | If less than one day hr. min.

9. Birthplace Va (Town, county, and state)

10. Usual Occupation Packing House

11. Industry or business

FATHER 12. Name

13. Birthplace NC

MOTHER 14. Maiden Name Annie Wilson

15. Birthplace NC

16 (a) Informant Records.

(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)

(c) Cemetery or crematory Mt Calvary

Location

18 (a) Funeral director Elroy O. Wilson

(b) Address 1000 Brantley Ave

19 (a) NOV 8 - 1944 (b) at Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1944 at 12 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 3 1944 to Nov. 4 1944 and that I last saw her alive on Nov 4 1944

Immediate cause of death: Cardiac failure — Duration

Due to Lobar pneumonia LLL + RLL Type I

Due to Type I Pneumococcus bacteremia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy: Lobar pneumonia

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus

Address Johns Hopkins Hosp Date signed 11/6/44

G22386

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 131a

Registered No. G22386

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days) 48

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5305 Hamlin Ave
(If rural give location)
(e) Citizen of foreign country? N.D. (Yes or No)
If yes, name country

3 (a) **FULL NAME** William Gauss

3 (b) If veteran, name war —

3 (c) Social Security Account No. 214-03-4012

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6/11/1896

8. AGE: Years	Months	Days	If less than one day
48	4	26	hr. min.

9. Birthplace Balto, Md (town, county, and state)
10. Usual Occupation Night Manager.
11. Industry or business

FATHER
12. Name Jacob Gauss
13. Birthplace Germany

MOTHER
14. Maiden Name Minnie - (Glick)
15. Birthplace Germany

16 (a) Informant Hospital Record.
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-44 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge
Location Pikesville, Md.

18 (a) Funeral director Loring Byers.
(b) Address 5005 Park Heights Ave

19 (a) (Date rec'd by registrar) (b) Huntingdon Hill

NOV 8 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944, at 5:10 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11/4 1944 to 11/7 1944, and that I last saw him alive on 11/7 1944.

Immediate cause of death Respiratory Failure due to Cerebral Hemorrhage

	Duration
Due to Hypertension	Unknown
Due to Nephritis	Unknown
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Earl K Patterson M.D.
M.D.
Address
Date signed 11/7/44

33670 G22387

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH V107

G22387
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 1/2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3023 McElderry St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Lydia Karol (Kemp)
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: divorced

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 1884

8. AGE: Years 60 | Months 7 | Days 26 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Henry Karol
13. Birthplace ?

MOTHER
14. Maiden Name Cathern Wehrlin
15. Birthplace Md

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 9/44 (month) (day) (year)
(c) Cemetery or crematory St Matthews
Location Balto Md

18 (a) Funeral director Wm J Dixon & Son
(b) Address 2008 Orleans St

19 (a) (Date rec'd by registrar) (b) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1944 at 10:25 P.M.

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 6 1944 to Nov 6 1944 and that I last saw her alive on Nov 6 1944

Immediate cause of death: Cardiac failure — Duration: 12 hrs
Due to: Bronchopneumonia — 2 days
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature William T. Dixon
Address Johns Hopkins Hosp Date signed 11/6/44

VS 150

G22388

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1927

G22388
Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Exact age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1019 N. Fulton Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 60 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore.
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1019 N. Fulton Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Nannie Gregory

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: white

6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 1868

8. AGE: Years 76 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Va.

10. Usual Occupation retired (Town, county, and state)

11. Industry or business

FATHER
12. Name ----
13. Birthplace ----

MOTHER
14. Maiden Name ----
15. Birthplace ----

16 (a) Informant Mr. Edwin L. Bevans
(b) Address 1019 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/8/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director John O. Mitchell Funeral
(b) Address 1900 Eutaw Place

19 (a) NOV 8 1944 (Date received by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1944 at 5 A.M

21. I certify that death occurred on the date above stated: that I attended deceased from Jan. 1943 to Nov. 6 1944, and that I last saw him or her alive on Nov. 5 1944

Immediate cause of death	Duration
Coronary occlusion	acute
Due to Coronary arterio-sclerosis	2 yrs ?
Due to Valvular Heart Disease	?
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Isaac H. Ferguson M. D.
Address 700 E. Fayette Date signed 11/7/44

Huntington Williams Health Officer

Dr. Ferguson - Box 602 Temple Garden Apts

G22389

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

108

G22389 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully answered. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER ST.
(c) Hospital or institution: ST. JOSEPH'S HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5218 IVANHOE AVENUE
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME MRS. ERNESTINE R. ROMEO

3 (b) If veteran, name war

3 (c) Social Security Account No. None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	Married

6 (b) Name of husband or wife MR. FRANK ROMEO
6 (c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Jan 9-1890

8. AGE: Years	Months	Days	If less than one day
54	9	9	hr. min.

9. Birthplace BALTIMORE MD.
(Town, county, and state)
10. Usual Occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name Paul Schubert
13. Birthplace Germany

MOTHER
14. Maiden Name Mary M
15. Birthplace Washington D.C.

16 (a) Informant Frank Romeo
(b) Address 5218 Ivanhoe Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10-1944 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Lott C. & B.M. Walters

18 (a) Funeral director Potts & Stucker
(b) Address Baltimore Md.

19 (a) Filed NOV 8 1944 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1944, at 5 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 25 1944 to Nov. 7 1944, and that I last saw HER alive on Nov. 7 1944

Immediate cause of death	Duration
CORONARY OCCLUSION	
Due to PNEUMONIA	4 WEEK
Due to	over
Other Conditions HYPERTENSION	UNKNOWN

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M. D.
Address St Joseph Hospital Date signed 11-7-44

G22390 A38291

BALTIMORE CITY HEALTH DEPARTMENT X
CERTIFICATE OF DEATH 33B

G22390 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Anne Arundel
(c) City or town ANNAPOLIS (If outside city or town limits, write RURAL and give town)
(d) Street No. 48 Fleet St (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Mabel Antoinette Albert

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: black | 6 (a) Single, married, widowed, or divorced: child

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-10-43

8. AGE: Years | Months: 11 | Days: 26 | If less than one day: hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name John Albert
13. Birthplace ? Md

MOTHER 14. Maiden Name Florence
15. Birthplace ? Md

16 (a) Informant
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory St Johns
Location Northwest St Ext.

18 (a) Funeral director Abel E. Linch
(b) Address 45 Northwest St Annapolis Md

NOV 8 - 1944 Huntington Williams (Date rec'd by Registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1944 at 1:45 A M

21. I certify that death occurred on the date above stated, that I attended deceased from Nov 5 1944 to Nov 6 1944 and that I last saw he alive on Nov 6 1944

Immediate cause of death: Respiratory failure — Duration
Due to: influenza bilateral meningitis
Due to:
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: w/f meningitis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Robert Kaye
Address JHH Date signed 11-8-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22391

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 46 B

G22391 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Md. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore Milford (If outside city or town limits write RURAL and give road)
(d) Street No. 3611 Latham Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Frank Bayer. Frank Bayer

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Nellie Bayer. Nellie Bayer
6 (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) January 4, 1877

8. AGE: Years	Months	Days	If less than one day
67	10	5	hr. min.

9. Birthplace Md Pikesville, Md. (Town, county, and state)
10. Usual Occupation Farmer.
11. Industry or business

FATHER
12. Name John G. Bayer
13. Birthplace Pikesville, Md.

MOTHER
14. Maiden Name Mary Magdelina Derr
15. Birthplace Pikesville, Md.

16 (a) Informant Mrs. Frank Bayer
(b) Address 3611 Latham Road, Milford

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10, 1944 (month) (day) (year)
(c) Cemetery or crematory Druid Ridge Cemetery
Location Pikesville, Md.

18 (a) Funeral director E. W. Pomeroy
(b) Address 4510 Liberty Heights Ave.

19 (a) NOV 8 1944 (Date received by registrar) (b)

VS 150

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1944, at 9.00 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 10-26 1944 to 11-7 1944 and that I last saw h[illegible] alive on 11-7 1944.

Immediate cause of death: Carcinoma of stomach — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature L. L. McCormack M. D.
Address Md. Gen. Hosp. Date signed 11-7-44

22392

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

G22392 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Sinai Hospital
(c) Hospital or institution: Monument & Rutland Ave
(d) Length of stay in hospital or inst. (yrs., mos., or days) 15
(e) Length of stay in Baltimore (yrs., mos., or days) 32 Yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1623 Moreland Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Geser, Henry

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Rebecca

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July, 15. 1889

8. AGE: Years	Months	Days	If less than one day
55	3	22	hr. min.

9. Birthplace Poland
(Town, county, and state)

10. Usual Occupation

11. Industry or business Tailoring

FATHER
12. Name Morris Geser
13. Birthplace Poland

MOTHER
14. Maiden Name Bena ?
15. Birthplace Poland

16 (a) Informant Rebecca Geser
(b) Address 1623 Moreland Ave

17 (a) Burial (b) Date thereof Nov. 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Hebrew Rosedale Cem
Location Hamilton Ave

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 1126 W North Ave

19 (Date rec'd by registrar) NOV 9 - 1944 Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1944, at 6:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1944 to Nov 7 1944, and that I last saw him alive on 6:00 P.M. Nov. 7 1944

Immediate cause of death Cardiac decompensation / failure — Duration

Due to Intracranial Hemorrhage

Due to Hypertension and arterio-sclerosis

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Leopold Locker M.D.
M. D.
Address Sinai Hosp. Date signed Nov 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. correct age is especially important.

MARGIN RESERVED FOR BINDING

G22393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 130

G22393 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2125 W. Fayette St.
(c) Hospital or institution: Bon Secours Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4700 York Road (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME John H. Morris

3 (b) If veteran, name war

3 (c) Social Security Account No. 216-03-5339

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	M

6 (b) Name of husband or wife Mrs. Mary F. Morris
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12/17/93

8. AGE: Years	Months	Days	If less than one day
50	10	25	hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Truck Driver. Salesman
11. Industry or business Morris Towel Co

FATHER
12. Name Walter Morris
13. Birthplace Va

MOTHER
14. Maiden Name Ella Sivler
15. Birthplace Va

16 (a) Informant Mary F. Morris
(b) Address 4700 York Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory Woodlawn
Location Woodlawn, Md.

18 (a) Funeral director William Cook Inc
(b) Address 1217 St. Paul st.

NOV 9 - 1944 (Date rec'd by local reg.) Huntington Williams M.D. (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7/44 19 44, at 10:57 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/1/44 19 to 11/7/44 19, and that I last saw him alive on 11/2/44 19

Immediate cause of death Subacute Glomerulonephritis — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Francis T. Grumbine M. D.
Address Date signed 11/7/44

G22394

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

937

G22394 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in especially important. Write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4203 Spring dale Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1402 Bolton St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Louisiana Bond

3 (b) If veteran, name war: No
3 (c) Social Security Account No. none

4. Sex: Female
5. Color or race: Black
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife:
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4 1844

8. AGE: Years 100 | Months 2 | Days 4 | If less than one day hr. min.

9. Birthplace (Town, county, and state) Baltimore Md

10. Usual Occupation none

11. Industry or business

FATHER
12. Name Dr Thomas E Bond
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Virginia Morris
15. Birthplace Philadelphia Pa

16 (a) Informant Mrs John Palagruta
(b) Address 1305 Bolton St

17 (a) Burial (Burial, cremation or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Baltimore Md

18 (a) Funeral director Milton Sloan
(b) Address 1 E Pratt St

19 (a) NOV 9 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 190

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1944 at 12 25 AM

21. I certify that death occurred on the date above stated; that I attended deceased from July 1938 to Nov 8 1944 and that I last saw h[illegible] alive on Nov 8 19 44.

Immediate cause of death
Myocardial degeneration
Arterio sclerosis
Due to Bronchio-pneumonia

Duration
Hrs.
2-3 days

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature W H Hardy M.D.
Address 1403 Park Ave Date signed 11/8/44

G22395

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

131a

Registered No. G22395

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 316 W Belvedere Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 316 W Belvedere Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Laura A Schwind

3 (b) If veteran, name war: No
3 (c) Social Security Account No. None

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Adolph F

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 4, 1876

8. AGE: Years 68 | Months 7 | Days 3 | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name John O'Keefe
13. Birthplace Unknown

MOTHER
14. Maiden Name Lama Schaf
15. Birthplace Md

16 (a) Informant Adolph Schwind
(b) Address 316 W Belvedere Ave Balto Md

17. Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt Auburn
Location Baltimore Md

18 (a) Funeral director Fullerton & Son
(b) Address 2114 E Pratt St

19 NOV 9 - 1944 (Date rec'd by registrar) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944, at 7:45 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 7 1944 and that I last saw h CY alive on Nov 7 1944.

	Duration
Immediate cause of death: Coronary Thrombosis	1 day
Due to: Cardio-renal-Vascular Disease	7yrs
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)

Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J N Nelson M.D.
Address 617 W. 40th St Date signed 11/13/44

G22396

YA-82280

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

12 B

G22396 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Avenue
(c) Hospital or institution:
BALTIMORE CITY HOSPITALS 26
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 yr. 4 mos. 12 days
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Elkton
(If outside city or town limits, write RURAL and give town)
(d) Street No. Route #1
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Marvin Taylor

3 (b) If veteran, name war W
3 (c) Social Security Account No. None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 8, 1908

8. AGE: Years 36 | Months 1 | Days | If less than one day hr. min.

9. Birthplace Virginia (Town, county, and state)
10. Usual Occupation Sheet Metal Worker
11. Industry or business ?

FATHER
12. Name Sylvanus Taylor
13. Birthplace Va.

MOTHER
14. Maiden Name Lillie Breeden
15. Birthplace Va.

16 (a) Informant BALTIMORE CITY HOSPITALS
(b) Address (RECORDS)

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory Joliette
Location Cage Co Va

18 (a) Funeral director Wilson Funeral Home
(b) Address 1214 E Pond

19 NOV 9 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8, 1944, at 3:40 pm

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944 to Nov 8 1944, and that I last saw him alive on Nov 8 1944

Immediate cause of death: Heart failure — Duration: 24 hrs.
Due to: Pulmonary tuberculosis — Duration: 2 years
Due to — Duration:
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Hugh H. Gibbon
Address Balto City Hosp Date signed 11/8/44 M. D.

G22397

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

119a

Registered No. G22397

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Univ. Hospital, Baltimore
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3 days
(e) Length of stay in Baltimore (yrs., mos., or days) 21 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1317 Woodyear St.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Gilbert Sewell
3 (b) If veteran, name war
3 (c) Social Security Account No.
4. Sex M
5. Color or race Black
6 (a) Single, married, widowed, or divorced. Single
6 (b) Name of husband or wife
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 10/16/44
8. AGE: Years | Months | Days 21 | If less than one day hr. min.
9. Birthplace Baltimore, Maryland (Town, county, and state)
10. Usual Occupation None
11. Industry or business

MOTHER / FATHER
12. Name Daniel
13. Birthplace Md.
14. Maiden Name Burrell
15. Birthplace Va.

16 (a) Informant Mother
(b) Address 1317 Woodyear St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 9, 1944 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.

18 (a) Funeral director Mrs. Leo H. Holland
(b) Address 1651 Druid Hill Ave.

Nov 9 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1944 at 12:00 Noon M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-3 1944 to 11-7 1944 and that I last saw h.l.m. alive on 11-7 1944.

Immediate cause of death Respiratory failure — Duration

Due to Pneumonia

Due to Diarrhea

Other conditions Anemia Pulmonary Edema
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas J. Elias M. D.
Address Univ. Hospital Date signed 11-7-44

G22393

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

55N Registered No. G22398

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 7
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1834 E. Madison St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Arthur Hawkins

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Juanita | 6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 6-12-96

8. AGE: Years 48 | Months 4 | Days 24 | If less than one day hr. min.

9. Birthplace Md (Town, county, and state)

10. Usual Occupation Longshoreman

11. Industry or business

FATHER
12. Name Benson Hawkins
13. Birthplace Md

MOTHER
14. Maiden Name Alice Watkins
15. Birthplace Md

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 9, 1944
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt. Calvary
Location Baltimore Co. Md.

18 (a) Funeral director Thos. Leo. W. Hallett
(b) Address 1691 Druid Hill Ave

19 (c) NOV 9 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 189

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov - 6 1944; at 2:40 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 26 1944 to Nov 6 1944 and that I last saw him alive on Nov. 6 1944

Immediate cause of death Lymphosarcomatosis — Duration 1 month

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy Lymphosarcomatosis

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Albert A. Kattus
Address Johns Hopkins Hosp. Date signed 11/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22399

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

161c

Registered No. G22399

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hospital 615

(d) Length of stay in hospital or inst. (yrs., mos., or days) 6½ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 4 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1813 E. North Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Joseph Huber

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Single

6 (b) Name of husband or wife —

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 11-3-44

8. AGE: Years	Months	Days	If less than one day
0	0	4	— hr. — min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

MOTHER / FATHER
12. Name Joseph N. Huber
13. Birthplace —
14. Maiden Name Delores Schroefer
15. Birthplace —

16 (a) Informant Father
(b) Address

17 (a) Burial (b) Date thereof 11-9-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director L. Beck
(b) Address 5305 Harford Rd.

NOV 9 1944 (Date received by Registrar) Huntington Williams M.D. Registrar

VS 250

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1944, at 8:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 1:30 P.M. 11-7 1944, to 8:00 P.M. 11-7-1944, and that I last saw him alive on 7:59 P.M. 11-7-1944.

Immediate cause of death	Duration
Spontaneous Hemorrhagic Disease of Newborn	1 day
Due to	
Due to	
Other Conditions none	

(Include pregnancy within 3 months of death)

Date of operation none
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Wm. Carl Ebeling III M. D.
Address Univ. Hosp. Date signed 11-9-44

MARG. RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT ✓ Registered No. G22400

CERTIFICATE OF DEATH 157E

G22400

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 607 Pennsylvania Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Floyd Davis Taylor.

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex: M | 5. Color or race: C. | 6 (a) Single, married, widowed, or divorced: —

6 (b) Name of husband or wife —

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-14-1937

8. AGE: Years 7 | Months 3 | Days 22 | If less than one day ____hr. ____min.

9. Birthplace Kinston N. C. (Town, county, and state)

10. Usual Occupation School

11. Industry or business

FATHER 12. Name Austrian Williams
13. Birthplace N. C.

MOTHER 14. Maiden Name Nellie Elliott
15. Birthplace N. C.

16 (a) Informant James Elliott
(b) Address 607 Penna ave

17 (a) Shipped (Burial, cremation, or removal) (b) Date thereof 11-9-44 (month) (day) (year)
(c) Cemetery or crematory Kinston Cem
Location Kinston N. C.

18 (a) Funeral director William A Jasper
(b) Address 916 Penna ave

19 NOV 9 - 1944 (Date rec'd by registrar) Hartington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1944, at 6.55 P M

21. I certify that I took charge of the remains described above, held an Autopsy Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Infarction of Myocardium

Due to Anomaly of left coronary artery

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed Nov 7 1944

VS 151

G22401

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 48a

Registered No. G22401

AB-90088

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4940 Eastern Ave.
(c) Hospital or institution: Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mos-&-2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 20 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 658 West. Saratoga St. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Ethel Jefferson

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	C	Married

6 (b) Name of husband or wife Henry
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ?-?-?- (42 ?

8. AGE: Years	Months	Days	If less than one day
42 ?	?	?	hr. min.

9. Birthplace N.C. (Town, county, and state)
10. Usual Occupation Housework
11. Industry or business

FATHER
12. Name Jack Moore
13. Birthplace N.C.

MOTHER
14. Maiden Name Loula or Leula Andrews
15. Birthplace N.C.

16 (a) Informant Records) Baltimore City Hospitals
(b) Address 4940 Eastern Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-44 (month) (day) (year)
(c) Cemetery or crematory Mt. Auburn
Location Baltimore Md.
18 (a) Funeral director William G. Jackson
(b) Address 916 Penna. Ave

NOV 9 - 1944 (Date rec'd by registrar) Harrington Williams, M.D. Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1944 at 7.20 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10/5 1944, to 11/7 1944, and that I last saw h[illegible] alive on 11/7 1944.

Immediate cause of death Carcinoma of cervix & metastasis; secondary anemia — Duration ?
Due to
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy: no port

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature C. A. Perry M.D.
Address City Hosp. Date signed 11/8/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully s... correct age is especially important. Physicians: please write th... the causes of death clearly and legibly.

MARG... RESERVED FOR BI... ONLY

G22402

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

G22402 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. MARGINS RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoun
(c) Hospital or institution:
FRANKLIN Square Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3404 Child's Court
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Oldaker

3 (b) If veteran, name war: No
3 (c) Social Security Account No.: None

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single
6 (b) Name of husband or wife: None
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.)
8. AGE: Years | Months | Days | If less than one day: 1 hr. 15 min.
9. Birthplace Franklin Square Hospital (Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Ohley Oldaker
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name ARLOTTA Oldaker
15. Birthplace Baltimore, Md.

16 (a) Informant Father.
(b) Address 3404 Child's Court

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 9 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4 1944, at 10:42 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1944, to Nov. 4 1944, and that I last saw h.im alive on Nov. 4 1944.

Immediate cause of death	Duration
Congenital Atelectasis	1 day
Due to Prematurity (2' 6")	1 day
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide No
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 11-5-44

2281

G22403

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. G22403 159

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument St. & Cutland Ave.
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 2 hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County (If outside city or town limits, write RURAL and give town)
(d) Street No. 584 Edgewater Apts. Essex (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Miller
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	Newborn

6 (b) Name of husband or wife —
6 (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Nov. 1, 1944

8. AGE: Years	Months	Days	If less than one day
			2 hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual Occupation Newborn
11. Industry or business

FATHER
12. Name Walter Miller
13. Birthplace Iowa

MOTHER
14. Maiden Name Clara Elizabeth Cothernel
15. Birthplace Colorado

16 (a) Informant Elsa Miller
(b) Address 584 Edgewater Apts. Essex

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SURG. NOV 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

VS 3

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1944, at 10:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw him alive on Nov. 1 1944

Immediate cause of death Prematurity

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Paul M. Wasson M. D.
Address 1719 Eutaw Pl. Date signed

2278

G22404

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

159

G22404
Registered No.

MARGINS RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Fayette & Calhoan Streets
(c) Hospital or institution: FRANKLIN SQUARE HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days) 1 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3618 Morey Avenue (Rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Schutz

3 (b) If veteran, name war	3 (c) Social Security Account No.
No	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife None
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10-28-44

8. AGE: Years	Months	Days	If less than one day
			3 hr. 5 min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Infant
11. Industry or business —

FATHER
12. Name Elmer L. Schutz
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden Name Louise (Schutz) ?
15. Birthplace Maryland

16 (a) Informant Elmer L. Schutz
(b) Address 3618 Morey Ave.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 28 1944, at 6.30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 10-28 1944, to 10-28 1944, and that I last saw him alive on 10-28 1944.

Immediate cause of death	Duration
Premature at 5½ Mo.	1 day
Due to Spontaneous abortion at 5½ Months	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation None
Major findings of operation: —
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following: No
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature J. Carl Myers
Address Franklin Sq. Hosp. Date signed 10/30/44

VS 150

2230

G22405

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

Registered No. G22405

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully examined before it is written. Physicians: please write the causes of death clearly and legibly. Do not abbreviate. Omit words only when necessary. Answer all questions unless instructions are to the contrary. Be sure that the age is correct. Age is especially important. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: University Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 6 da 14
(e) Length of stay in Baltimore (yrs., mos., or days) Same

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County
(c) City or town Balto. (If outside city or town limits, write RURAL and give town)
(d) Street No. 221 E Bond St (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country N.G.

3 (a) FULL NAME Baby Boy Battle.
3 (b) If veteran, name war ✓
3 (c) Social Security Account No. ✓

4. Sex M | 5. Color or race B | 6 (a) Single, married, widowed, or divorced. S.

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 10/24/44

8. AGE: Years | Months | Days 6 | If less than one day hr. min.

9. Birthplace Balto Md. (Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name Elizabeth Battle
15. Birthplace

16 (a) Informant Hosp Records
(b) Address

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location UNIVERSITY MEDICAL SCHOOL NOV 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 (a) NOV 9 - 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 30 1944 at 2 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death Asphyxia

Due to Aspiration of vomitus

Due to Prematurity

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation

of autopsy

Duration: ½ Day; 6 da

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home; on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature [illegible] M.D.
Address Univ. Hosp Date signed 11-3-44

2282

G22406 G22406

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 159

Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully obtained. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1927 Harlem Ave
(c) Hospital or institution: —
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14
(e) Length of stay in Baltimore (yrs., mos., or days) 14 day

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL, and give town)
(d) Street No. 1927 Harlem Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country —

3 (a) FULL NAME Premature Birth (Baby Boy Major)

3 (b) If veteran, name war —
3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
M	W	single

6 (b) Name of husband or wife none
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) November 4, 1944

8. AGE: Years	Months	Days	If less than one day
—	—	—	10 hr. 40 min.

9. Birthplace Baltimore, Md (Town, county, and state)
10. Usual Occupation —
11. Industry or business —

FATHER
12. Name James Edwin Major
13. Birthplace Newport News Va

MOTHER
14. Maiden Name Dorothy Virginia Fowler
15. Birthplace Bolto, Md

16 (a) Informant Dorothy Virginia Fowler
(b) Address 1927 Harlem Ave Balto Md

17 (a) — (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Location UNIVERSITY MEDICAL SCHOOL NOV 8 1944

18 (a) Funeral director Commissioner of Health
(b) Address

19 NOV 9 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4, 1944 at 2 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 4 1944 to Nov 4 1944. and that I last saw h/m alive on Nov 4 1944.

Immediate cause of death Premature birth / Asphyxia — Duration 10 hrs

Due to Poor development of lungs & respiratory center

Due to —

Other Conditions —

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation: —

of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature J Earl Pass, M.D.
Address 4001 Wilkens ave Date signed 11-7-44

2279

VS 150

G22407

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

157E

G22407 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARK RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: The Johns Hopkins Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0
(e) Length of stay in Baltimore (yrs., mos., or days) 0

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1213 Caroline Street (If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Rufus Larry Parsons

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Black | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 20, 1944

8. AGE: Years | Months | Days | If less than one day: 15 hr. 45 min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual Occupation: Infant

11. Industry or business

FATHER
12. Name: Rufus Parsons
13. Birthplace: Virginia

MOTHER
14. Maiden Name: Bertha Blizzard
15. Birthplace: Virginia

16 (a) Informant: Hospital Records
(b) Address: Johns Hopkins Hospital

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location NOV 8 1944

18 (a) Funeral director: Commissioner of Health
(b) Address

19 NOV 9 - 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 21 1944, at 1:10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct. 20 1944, to Oct. 21 1944, and that I last saw him alive on Oct. 21 1944

Immediate cause of death: Congestive heart failure — Duration

Due to: ? congenital heart disease

Due to:

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature M. L. Griffith M. D.
Address Johns Hopkins Hospital Date signed 10-21-44

12283

G22408

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

61

Registered No. G22408

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calhoun & Fayette Sts
(c) Hospital or institution: Franklin Square Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 743 N. Fulton Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Kenneth R. Topper

3 (b) If veteran, name war ✓

3 (c) Social Security Account No. ✓

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Single ✓

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21, 1939

8. AGE: Years 5 | Months 4 | Days 17 | If less than one day hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Louis V. Topper
13. Birthplace Balto, Md

MOTHER
14. Maiden Name Helen F. Kenney
15. Birthplace Balto, Md.

16 (a) Informant Mr. Louis Topper
(b) Address 743 N. Fulton Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)

(c) Cemetery or crematory Govans Pres. Govans
Location Govans, Md.

18 (a) Funeral director John J. Gowner & Son
(b) Address 901 to 3 Wallace Street

19 NOV 9 1944 (Date rec'd by registrar) (b) Huntington Williams, M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7, 1944, at 2:30 A.M.

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Hyperglycemia

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D.
Medical Examiner
Date signed Nov. 7 1944

G22409

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

Registered No. G22409

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in years, months, days, hours, minutes, and the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3509 Mt.Pleasant Ave.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3509 Mt.Pleasant Ave.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William F.Krause

3 (b) If veteran, name war	3 (c) Social Security Account No.
--	none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Widower

6 (b) Name of husband or wife Margaret Krause
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov.15,1869

8. AGE: Years	Months	Days	If less than one day
74	11	21	hr. min.

9. Birthplace Balto.Md.
(Town, county, and state)
10. Usual Occupation none
11. Industry or business

FATHER
12. Name Jacob F.Krause
13. Birthplace Germany

MOTHER
14. Maiden Name Christina --
15. Birthplace Germany

16 (a) Informant Mrs.Collini
(b) Address 3509 Mt.Pleasant Ave.

17 (a) Burial (b) Date thereof Nov.9/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Mt.Carmel Cem.
Location Balto.Md.

18 (a) Funeral director Philip Stewart Sons
(b) Address 2024 Orleans St.

NOV 9 - 1944 Huntington Williams, M.D.
(Date rec'd by registrar)

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov.6th.1944 19 , at M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov.5 1944, to Nov.6 1944, and that I last saw [illegible] alive on Nov.6 1944

Immediate cause of death	Duration
Coronary Thrombosis	1 day
Due to	
Due to Senile arterio-Sclerosis	4y
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature H. Valentine M.D.
Address 1926 No Broadway Date signed Nov 8-44

G22410

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

Registered No. G22410

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4006 St Paul St
(c) Hospital or institution: at Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0 12
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 4006 St Paul St (If rural give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country —

3 (a) FULL NAME Katherine Burgess Linn

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Dr. W. F. Linn
6 (c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.): March 3 1887

8. AGE: Years 57 | Months 8 | Days 4 | If less than one day: hr. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual Occupation: none
11. Industry or business: none

FATHER — 12. Name: Millard F. Burgess
13. Birthplace: Baltimore

MOTHER — 14. Maiden Name: Mollie J. Anderson
15. Birthplace: Baltimore

16 (a) Informant: Dr. W. F. Linn (husband)
(b) Address: 4006 St Paul St.

17 (a) (Burial, cremation, or removal): (vault) (b) Date thereof: (month) Nov 4 (day) (year) 44
(c) Cemetery or crematory: Greenmount
Location: Baltimore

18 (a) Funeral director: Stewart & Morgan Co.
(b) Address: 16 W Mount Ave.

19 (a) (Date received by registrar): NOV 9 - 1944 (b) Registrar: Huntington Williams, M.D.

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1944 at 10 45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 24 1944, to Nov 7 1944, and that I last saw h[illegible] alive on Nov 7 1944

Immediate cause of death	Duration
Myocarditis	
Due to Hypertension	
Due to [redacted]	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature: Worthington Ford, M.D.
Address 20 E. Preston St Date signed 11/8/44

G22411

GRAY

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH ✓ 108

Registered No. G22411

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age in years, months, days, and hours; the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 660 W Saratoga St
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County A
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 660 W Saratoga St (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Bertha Gray

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Fem | 5. Color or race: Col | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Arthur Gray
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25 1904

8. AGE: Years 39 | Months 10 | Days 12 | If less than one day hr. min.

9. Birthplace Buffalo – Va. (Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER 12. Name Unknown
13. Birthplace

MOTHER 14. Maiden Name
15. Birthplace

16 (a) Informant Mr. Arthur Gray
(b) Address 660 W. Saratoga St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-10-44 (month) (day) (year)

(c) Cemetery or crematory Mt Auburn
Location Mt. Winans

18 (a) Funeral director Mrs Kate R Williams
(b) Address 322 N Schroeder St

NOV 9 – 1944 (Date rec'd by Local Reg.) (b) Huntington Williams M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 7 1944 at 1:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944 to Nov 7 1944 and that I last saw h[illegible] alive on Nov 7 1944

Immediate cause of death Coronary Thrombosis | Duration 2 hr

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible]

Address [illegible] Date signed 11/8/44

G22412

BALTIMORE CITY HEALTH DEPARTMENT X

CERTIFICATE OF DEATH 1950

G22412 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the cause of death clearly and legibly. Information as to correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address ~~313 Riverside Road "75"~~
(c) Hospital or institution: University Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 day
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 313 Riverside Road
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME Gerald Eugene Shumar

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8-1942

8. AGE: Years 1 | Months 21 | Days 29 | If less than one day hr. min.

9. Birthplace Pennsylvania (Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Robert David Shumar
13. Birthplace Penn.

MOTHER
14. Maiden Name Sarah Christine Pfeffer
15. Birthplace Penn

16 (a) Informant Father
(b) Address Savage

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10-44 (month) (day) (year)
(c) Cemetery or crematory Cedar Hill
Location Gov. Ritchie Highway

18 (a) Funeral director Milton Schilling
(b) Address 3914 E. Hoffman St. Huntingtown Williams, Md.

19 (a) NOV 9 1944 (Registrar) Registrar

VS 180

MEDICAL CERTIFICATION

20. DATE OF DEATH November 7 1944, at 3:20 PM.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 6 1944, to Nov 7 1944, and that I last saw him alive on Nov 7 1944.

	Duration
Immediate cause of death Respiratory Failure	
Due to aspiration of foreign material into lung.	
Due to	
Other Conditions None	

(Include pregnancy within 3 months of death)

Date of operation —

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature [illegible]
Address University Hospital Date signed 11-9-44 M. D.

G22413

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22413 Registered No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address or location: Lafayette & John
(c) Hospital or institution: Hosp. for Women of Maryland
(d) Length of stay in hospital or inst. (yrs., mos., or days) 4d
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4007 Forest Park Ave
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mrs NANNIE TRAMMELL HOOS

3 (b) If veteran, name war: No.

3 (c) Social Security Account No.: None

4. Sex: F

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Wid

6 (b) Name of husband or wife: Geo. Wm Hoos

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 8 Dec 1884

8. AGE: Years 56 | Months 11 | Days 0 | If less than one day hr. min.

9. Birthplace Baltimore Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER
12. Name Joshua Stephens
13. Birthplace Georgia

MOTHER
14. Maiden Name Anna C. Rea
15. Birthplace Cambridge

16 (a) Informant Mrs. Tony L. Watkins
(b) Address 4007 Forest Pk ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Wm J. Fickus + Sons
(b) Address Balto - Md.

19 Date received NOV 9 1944 (b) Registrar Huntington Williams, M.D.

VS 8

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 November 1944 at 4:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 5 Nov 1944 to 8 Nov 1944, and that I last saw her alive on 8 Nov 1944.

Immediate cause of death: Card. Resp. failure — Duration

Due to: Cerebrovascular Hemorrhage

Due to: Hypertensive Cardiovascular disease

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Wm. H. Speed III M. D.
Address Women's Hospital Date signed 11-8-44

1957 G22414

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 107

G22414
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 606 S Washington
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Maggie Labedziewska (Magdalena Labedzieski)

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband or wife Martin Labedziewska
6 (c) If alive, give age 7 years

7. Birth date of deceased (mo., day, yr.) May 17 1874

8. AGE: Years	Months	Days	If less than one day hr.	min.
70	5	21		

9. Birthplace Poland (Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name Michael Staszynski
13. Birthplace Poland

MOTHER
14. Maiden Name Livia Slawik
15. Birthplace Poland

16 (a) Informant records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (b) Date thereof Nov. 11/44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory St Stanislaus Cem.
Location Baltimore City

18 (a) Funeral director John M. Weber
(b) Address 401 S. Chester Street

19 (a) NOV 9 1944 Huntington Williams M.D.
(Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1944 at 2:50 A.M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 9-44 to Nov 7 1944 and that I last saw h alive on Nov-7 1944

Immediate cause of death Respiratory failure — Duration
Due to Bronchopneumonia — 2 days
Due to
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation
Major findings of operations:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature H. A. T. Dorton
Address Johns Hopkins Hosp. Date signed Nov 9/44

VS 150

G22415

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22415 Registered No. 1210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1006 Scott St.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) V
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Scott St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME George M. Kummel

3 (b) If veteran, name war: no
3 (c) Social Security Account No.: none

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Carrie L. Kummel
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 1. 1870

8. AGE: Years	Months	Days	If less than one day
73	11	7	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)
10. Usual Occupation Blue Print Layer.
11. Industry or business Koppers Co.

FATHER
12. Name Frank C. Kummel
13. Birthplace Germany

MOTHER
14. Maiden Name Anna M. Grubert
15. Birthplace Germany

16 (a) Informant Elizabeth Kummel
(b) Address 1006 Scott St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11. 1944 (month) (day) (year)
(c) Cemetery or crematory London Park
Location City

18 (a) Funeral director Mrs. John W. Teufel & Son
(b) Address 801 W. Fayette St.

19 (a) (Date rec'd by registrar) (b) Registrar Huntington Williams, MD
NOV 10 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1944, at 4a M

21. I certify that death occurred on the date above stated; that I attended deceased from 8-5 1942 to 11-8 1944 and that I last saw h[illegible] alive on 11/8 1944

Immediate cause of death: Acute Cardiac Failure — Duration: 1da
Due to: Chronic Myocarditis — Duration:
Due to: Generalized Arteriosclerosis — Duration: 2yr
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Joseph L. Lanahan
Address 625 W. Washington St. Date signed 11/9/44

G22416

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 562

G22416
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1211 Light St.
(c) Hospital or institution: South Balto. Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 17 da.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 232 E Montgomery St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Flair H. Reynolds

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Isaac L. Reynolds
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 22, 1913

8. AGE: Years 31 | Months 8 | Days 18,19 | If less than one day hr. min.

9. Birthplace Va.
(Town, county, and state)

10. Usual Occupation Housework

11. Industry or business

FATHER
12. Name Dudley M. Saundley
13. Birthplace Va

MOTHER
14. Maiden Name Mary Jamison
15. Birthplace Va.

16 (a) Informant Isaac Garnett Reynolds
(b) Address 232 E. Montgomery St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory Oakwood
Location Martinsville, Va.

18 (a) Funeral director John F Fleming Inc
(b) Address 711 Light St.

NOV 9 - 1944
(Date rec'd by registrar) (b) Huntington Williams, M.D.

VS 188

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-9 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw h[illegible] alive on 11-9 1944.

Immediate cause of death: Shock
Due to: abdominal abscess post operative and
Due to: intestinal obstruction.
Other Conditions

(Include pregnancy within 3 months of death)
Date of operation 10-27-44 - 11-3-44
Major findings of operation: abdominal abscess, fibroids intest. obst.
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature George Burnett M.D.
M. D.
Address Louisburg, Va. Date signed 11-9-44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

G22417

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

121a

G22417 Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4013 Liberty Heights Ave.
(c) Hospital or institution: Alberta Nursing Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 5 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Talbot
(c) City or town Easton
(If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3 (a) FULL NAME Belle H. Smith

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: female | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Wallace N. Smith
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1854

8. AGE: Years	Months	Days	If less than one day
89	11	23	hr. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual Occupation: none
11. Industry or business

FATHER
12. Name: ? Harris
13. Birthplace: Va.

MOTHER
14. Maiden Name: ? Thomas
15. Birthplace: Va.

16 (a) Informant: T. Harris Smith
(b) Address: Easton, Md.

17 (a) cremation (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park
Location: 3801 Frederick Ave.

18 (a) Funeral director: John O. Mitchell & Sons Co. Huntington Ave.
(b) Address: 1900 Eutaw Place

19 (a) (b) Registrar

NOV 9 - 1944

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6 1944, at 10:30 P. M.

21. I certify that death occurred on the date above stated; that I attended deceased from 9/22/1938 19..., to 11/6/1944, and that I last saw her alive on 11/4/44 19....

Immediate cause of death: Cardio-vascular-renal disease with uraemia. — Duration

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature: Edwin B. Jarrett
Address: 11 E. Chase St. Date signed 11/9/44

Edwin B. Jarrett

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G22418

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 93D

G22418
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 4111 Northern Pky.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7m
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Balto
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4111 Northern Pky
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Catherine Gebhardt

3 (b) If veteran, name war —

3 (c) Social Security Account No. None

4. Sex F | 5. Color or race W. | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife John

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 23 1862

8. AGE: Years 81 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Balto. (town, county, and state)

10. Usual Occupation At Home

11. Industry or business

FATHER
12. Name George Hahn
13. Birthplace Germany

MOTHER
14. Maiden Name Catherine ?
15. Birthplace Germany

16 (a) Informant Margaret Smith
(b) Address 4111 Northern Pky.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd.

18 (a) Funeral director M. W. E. Dupuis & Son
(b) Address Lombard & Arlington

19 (a) (Date received by local registrar) NOV 9 1944 (b) Huntington Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 7 1944 at 2:30 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 15 1944 to Nov 7 1944 and that I last saw h alive on Nov 6 1944.

Immediate cause of death	Duration
Terminal Pneumonia	10 h
Due to Chronic Hypertension, Heart	Yrs.
Dis - Arteriosclerosis	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
Signature G. H. Mesmer M.D.
Address 1520 E. 33rd St. Date signed 11/7/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

G22419

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

122 B

G22419

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Calvert & Saratoga Sts
(c) Hospital or institution:
Mercy Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days) 2 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Wateroak Point
(If outside city or town limits, write RURAL and give town)
(d) Street No. Pasadena
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James McNabb
3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Harriett S. McNabb (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 2-28-1879

8. AGE: Years	Months	Days	If less than one day
65	8	10	hr. min.

9. Birthplace Scotland (Town, county, and state)
10. Usual Occupation retired
11. Industry or business

FATHER
12. Name William McNabb
13. Birthplace Scotland

MOTHER
14. Maiden Name Elizabeth - (?)
15. Birthplace Scotland

16 (a) Informant Hospital Records
(b) Address

17 (a) Burial (b) Date thereof 11-10-44
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Parkwood
Location Baltimore

18 (a) Funeral director Leonard J. Ruck
(b) Address 5305 Harford Rd

NOV 9 1944 (Huntington Williams, M.D.)
(Registrar's signature) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th 1944 at M

21. I certify that death occurred on the date above stated; that I attended deceased from NOV 6 1944 to NOV 8 1944, and that I last saw h[illegible] alive on NOV 7 1944.

Immediate cause of death	Duration
Peritonitis - ? Sarcoma of Small Bowel	2 days
Due to obstruction of bowel due to adhesions	5 days
Due to	
Other Conditions -	

(Include pregnancy within 3 months of death)
Date of operation NOV. 7, 1944
Major findings of operation: Sarcoma of Jejunum 12 inches
of autopsy: None -

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury
23. Signature John Michael Parker M.D.
M. D.
Address Date signed

MARG[illegible] RESERVED FOR BL[illegible]ING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22420

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22420 Registered No. 1248

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address CAROLINE & OLIVER ST
(c) Hospital or institution: ST. JOSEPH'S HOSP.
(d) Length of stay in hospital or inst. (yrs., mos., or days) 1 Mo. 23 days
(e) Length of stay in Baltimore (yrs., mos., or days) LIFE

2. USUAL RESIDENCE OF DECEASED:
(a) State MD (b) County —
(c) City or town BALTIMORE MD (If outside city or town limits, write RURAL and give town)
(d) Street No. 7133 HARFORD RD (If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME CHRISTOPHER A. MEYERS

3 (b) If veteran, name war None

3 (c) Social Security Account No. None

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. M

6 (b) Name of husband or wife PAULINE MEYERS

6 (c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) AUG. 2, 1878

8. AGE: Years 66 | Months 3 | Days 6 | If less than one day ##### min.

9. Birthplace BALTIMORE, MD. (Town, county, and state)

10. Usual Occupation CLERK

11. Industry or business UNEMPLOY. COMP. STATE OF MD

FATHER
12. Name Francis X. Meyers
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Doetsch
15. Birthplace Baltimore Md.

16 (a) Informant Mrs. Anna Hess (Sister)
(b) Address 7133 Harford Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Belair Rd. Balto; Md.

18 (a) Funeral director George J. Ruth, Inc.
(b) Address 1735 Harford Avenue

19 (a) (Date received by Registrar) NOV 9 1944

Hunting for Williams, [illegible]

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8 1944, at 5 P M

21. I certify that death occurred on the date above stated; that I attended deceased from 9/16 1944, to 11/8 1944, and that I last saw him alive on 11/8 1944

Immediate cause of death CARDIAC FAILURE — Duration

Due to CIRRHOSIS OF LIVER

Due to

Other Conditions PNEUMONIA ARTERIOSCLEROSIS
(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Thomas Brennan M.D.
Address St. Joseph Hospital signed 11-9-44

G22421

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1937

G22421
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 6821 Reisterstown Rd
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) N
(e) Length of stay in Baltimore (yrs., mos., or days) 65 yrs.

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Balto
(c) City or town Rural
(If outside city or town limits, write RURAL and give town)
(d) Street No. 6821 Reisterstown Rd.
(If rural give location)
(e) Citizen of foreign country? — (Yes or No)
If yes, name country

3 (a) FULL NAME Harry J. Hartman

3 (b) If veteran, name war: none
3 (c) Social Security Account No. none

4. Sex: Male
5. Color or race: White
6 (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Nellie M. Carbaugh
6 (c) If alive, give age: 70 years
7. Birth date of deceased (mo., day, yr.): April 6 1878
8. AGE: Years 66 | Months 7 | Days 2 | If less than one day: hr. min.
9. Birthplace: Balto Co. Md
(Town, county, and state)
10. Usual Occupation: Farmer
11. Industry or business:

FATHER
12. Name: August Hartman
13. Birthplace: Germany

MOTHER
14. Maiden Name: Lena Ohrman
15. Birthplace: German

16 (a) Informant: Nellie M. Hartman
(b) Address: 6821 Reisterstown Rd.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory: Druid Ridge
Location: Pikesville
18 (a) Funeral director: Frank A. Newell
(b) Address: Pikesville, Md

NOV 9 1944 (b) Registrar
(Date rec'd by Registrar)

VS 180

Huntington Williams, MD

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/7 1944, at 10 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 1/8 1942 to 11/7 1944, and that I last saw h[illegible] alive on 11/7 1944

Immediate cause of death: Chronic Myocarditis — Duration: 2 yrs
Due to: Coronary Sclerosis — 2 yrs
Due to: Art. Sclerosis — 2 yrs
Other Conditions:
(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury:
23. Signature: James H. Neville MD
Address: Pikesville, Md Date signed 11/9/44

G22422

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH 46 H

G22422
Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Bon Secour Hosp
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 10 days

2. USUAL RESIDENCE OF DECEASED:
(a) State ~~Ohio~~ Pa (b) County
(c) City or town Philadelphia
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5040 Market St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Daisy L. BORRIER

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex F | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married.

6 (b) Name of husband or wife Harry E. Borrier
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 13, 1891

8. AGE: Years 53 | Months 4 | Days 27 | If less than one day hr. min.

9. Birthplace Ohio
(Town, county, and state)

10. Usual Occupation none

11. Industry or business

FATHER
12. Name James Scott McElroy
13. Birthplace Ohio

MOTHER
14. Maiden Name Jennie Sulz
15. Birthplace Ohio

16 (a) Informant Harry E. Borrier
(b) Address 5040 Market St Phila Pa

17 (a) Cremated (b) Date thereof Nov 9/44
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Hanover Co. Ohio
Location Ohio

18 (a) Funeral director Philips Mearig Bros
(b) Address 2024 O'Hara St

NOV 9 1944
19 (a) (Date rec'd by registrar) (b) Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/9 1944 at 1 25 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/5 1944 to 11/9 1944 and that I last saw her alive on 11/9 1944.

Immediate cause of death: Acute Pulmonary Edema — Duration 5 hrs.
Due to Post. Hemorrhage
Due to
Other Conditions Syphilis - Sarcoma mesenteric to lung.
(Include pregnancy within 3 months of death)
Date of operation 11/7/44
Major findings of operation: Metastatic sarcoma mesenteric
of autopsy: None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide —
(b) Date of occurrence — at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? — While at work?
(Specify type of place)
(e) Means of injury

23. Signature Sigmund Rayer M. D.
Address Bon Secours Hosp Date signed 11/9/44

Huntington Williamsville, Mass

G22423

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

G22423
Registered No. 1600

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Monument & Caitland Ave
(c) Hospital or institution: Sinai
(d) Length of stay in hospital or inst. (yrs., mos., or days) 3¾ hrs
(e) Length of stay in Baltimore (yrs., mos., or days) 3¾ hrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3711 Maple Drive. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Baby Boy Belaga

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
male	White	newborn

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 9, 1944

8. AGE: Years	Months	Days	If less than one day
			3 hr. 45 min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation newborn

11. Industry or business

FATHER
12. Name Jack Belaga
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Shirley Brill
15. Birthplace Baltimore Md

16 (a) Informant Shirley Belaga
(b) Address 3711 Maple Drive.

17 (a) Buried (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Mt Carmel
Location 6500 Odonnell St

18 (a) Funeral director Sol Levinson & Bros
(b) Address 1124 W North ave

NOV 9 1944 (b) Irvington Williams, M.D. Registrar

VS 2

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1944, at 7:45 AM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw h alive on Nov. 9 19 44

Immediate cause of death	Duration
prob. atelectasis	
Edematous lung	
Due to	
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operations

of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature M. Stein
Address Sinai Hospital Date signed 11/9/44 M.D.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important.—Physicians: please write the causes of death clearly and legibly.

G22424

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

G22424
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Baltimore
(c) City or town Dundalk
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2904 Sage Drive
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Adcock

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-30

8. AGE: Years 14 | Months 4 | Days 5 | If less than one day hr. min.

9. Birthplace Va
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name Sidney Adcock
13. Birthplace Va

MOTHER
14. Maiden Name Lucy - Duff
15. Birthplace Va

16 (a) Informant Records
(b) Address JOHNS HOPKINS HOSPITAL

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11-44 (month) (day) (year)
(c) Cemetery or crematory Glen Haven Memorial Cem
Location Glenburnie Md

18 (a) Funeral director Whitney Schelling
(b) Address 2914 E. Hoffman St

NOV 9 - 1944 (Date received by registrar) (b) Huntington Williams M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 1 1944 at 7 45 M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1 1944 to Nov 1 1944 and that I last saw h er alive on Nov. 1 1944

Immediate cause of death: Respiratory Failure — Duration: 10 min.
Due to: Meningococcal meningitis — 36 hrs
Due to:
Other Conditions: Increased Intracranial Pressure
(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Abraham Cantor
Address Johns Hopkins Hospital Date signed 11-8-44

G22425

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1944

G22425
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 33rd. and Calvert Sts.
(c) Hospital or institution: Union Memorial Hospital
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2425 Lake View Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME Mr. Isaac Block

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of ~~husband or~~ wife Fannie Block
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 1870

8. AGE: Years	Months	Days	If less than one day
74	3	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation Retired
11. Industry or business

FATHER
12. Name Louis Block
13. Birthplace Baltimore, Md

MOTHER
14. Maiden Name Mary Wolfson
15. Birthplace Baltimore, Md

16 (a) Informant Mrs. C. Schwartzberg
(b) Address 2425 Lakeview Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/12/44 (month) (day) (year)
(c) Cemetery or crematory Hebrew Friendship
Location Baltimore, Md.

18 (a) Funeral director Harris Funeral Home
(b) Address 1901 Eutaw Place

NOV 9 - 1944
(Date rec'd by registrar)
(b) Huntington Williams M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11/8/44 19 , at 3:20 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11/2/44 19 to 11/8/44 19 , and that I last saw him alive on 11/8/44 19

Immediate cause of death	Duration
Cardiorespiratory Failure	
Due to Coronary Thrombosis	48 hours
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

25. Signature John D. Morris, M.D.
M. D.
Address UMH Date signed 11/9/44

VS 180

MARYLAND RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22426

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 94a

G22426 Registered No.

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3213 Bancroft Road
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Lifetime

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 3213 Bancroft Road.
(If rural give location)
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3 (a) FULL NAME DAISY B. SONNEBORN

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband ~~or wife~~ Lee Sonneborn
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 12, 1868

8. AGE: Years	Months	Days	If less than one day
76	8	27	26 hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation None
11. Industry or business

FATHER
12. Name David Bamberger,
13. Birthplace Germany.

MOTHER
14. Maiden Name Johanna Adler,
15. Birthplace Germany.

16 (a) Informant Mr. David Sonneborn (Son)
(b) Address 3213 Bancroft Road.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/10/44. (month) (day) (year)
(c) Cemetery ~~or crematory~~ Baltimore Hebrew
Location Balto. Md.

18 (a) Funeral director Harry Sonneborn Sons
(b) Address 1902 Eutaw Place.

19 (a) (Date received by registrar) (b) Huntington Williams, M.D.
NOV 9 - 1944

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 8th. 1944 at 4:30 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 1939 to Nov. 8, 1944, and that I last saw her alive on Oct 26, 1944

Immediate cause of death	Duration
Coronary occlusion	1 hour
Due to Arterio-sclerosis	3 yrs.
Due to	
Other Conditions	

(Include pregnancy within 3 months of death)
Date of operation
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Nathan B. Herman M.D.
Address 1041 St. Paul St. Date signed 11/9/44

Nathan B. Herman

G22427

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

85

G22427
Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: South Baltimore Hosp
(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 days
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 W. Cross St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Samuel Freeman

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M

5. Color or race C

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1896

8. AGE: Years 48 | Months | Days | If less than one day hr. min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name Ernest Freeman
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Emma Jones
15. Birthplace Baltimore Md

16 (a) Informant Annie Lee
(b) Address 1907 Creek Alley

17 (a) Burial (b) Date thereof 11/4/44 (month) (day) (year)
(Burial, cremation, or removal)
(c) Cemetery or crematory Balto National
Location Balto Md

18 (a) Funeral director Daniel L. Provant Son
(b) Address 1014 W Montgomery St

19 (a) (Date received by local registrar) (b) Washington Village Md

NOV 10 1944

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH 10/30 1944, at 2:45 AM

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained (Autopsy, Inspection or Inquiry)
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Epilepsy

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Hugh B. McKelvey Medical Examiner.
Date signed 10/30/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22423 — BALTIMORE CITY HEALTH DEPARTMENT — G22423 Registered No. 50

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Please write the correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3301 Guilford Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3301 Guilford Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Connie O Miller

3 (b) If veteran, name war: W
3 (c) Social Security Account No. none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 23 1871

8. AGE: Years	Months	Days	If less than one day
73 73	0	15	hr. min.

9. Birthplace Ga. (Town, county, and state)
10. Usual Occupation Retired Ins. Agent
11. Industry or business Mass. Mutual Life
12. Name of Father: Thomas H Miller
13. Birthplace of Father: Georgia
14. Maiden Name of Mother: Virginia Webb
15. Birthplace of Mother: Georgia
16 (a) Informant Mrs. Alice Miller
(b) Address 3301 Guilford Ave.
17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory Mt. Olivet
Location Balto. Md.
18 (a) Funeral director William Cook Inc
(b) Address 121 St. Paul St.
19 (a) (Date received by Local Registrar) NOV 10 1944 Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8 1944, at 10:45 P M
21. I certify that death occurred on the date above stated; that I attended deceased from 9-17 1925 to 11-8 1944. and that I last saw h.er alive on 11-8 1944.

Immediate cause of death	Duration
Carcinoma of Left breast	
Due to	
Due to	
Other Conditions Myocarditis Hypostatic pneumonia (Include pregnancy within 3 months of death)	12 hrs

Date of operation Refused
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injufy occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury
23. Signature Chas C. Judd M. D.
Address 222 Wendover Rd Date signed 11-9-44

Huntington Williams, M.D.

G22429

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 330

G22429 Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3506 Spaulding Ave
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) 27-18
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Balto (If outside city or town limits, write RURAL and give town)
(d) Street No. 3506 Spaulding Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Myrtle Mae Peterson

3 (b) If veteran, name war: NI
3 (c) Social Security Account No.: NONE

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband: Walter E. Peterson
6 (c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 29th 1886

8. AGE: Years	Months	Days	If less than one day
58	4	9	hr. min.

9. Birthplace: Washington Kansas (Town, county, and state)
10. Usual Occupation: Housework
11. Industry or business: Own Home

FATHER
12. Name: George Direly
13. Birthplace: Penna.

MOTHER
14. Maiden Name: Anna (Un Known)
15. Birthplace: Missouri

16 (a) Informant: Walter E. Peterson
(b) Address: 3598 Spaulding Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-11-44 (month) (day) (year)
(c) Cemetery or crematory: Balto. Cem.
Location: W. North Ave.

18 (a) Funeral director: William Cook Inc.
(b) Address: 1217 St Paul St.

19 (a) NOV 10 1944 (Date received by Registrar) Registrar

Huntington Williams, M.D.

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 8th 1944, at 4 45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 2nd 1944 to Nov 8th 1944 and that I last saw h[er] alive on Nov 8th 1944

	Duration
Immediate cause of death: Broncho Pneumonia	5 Days
Due to: Erysipelas Bronchitis	3 days
Due to:	
Other Conditions:	

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury:

23. Signature: F. Dawson
Address: 1 E. Randall St. Date signed: 11/9/44 M.D.

G22430 BALTIMORE CITY HEALTH DEPARTMENT G22430

CERTIFICATE OF DEATH 94a

Registered No.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Maryland General Hospital 16
(d) Length of stay in hospital or inst. (yrs., mos., or days) 5 days
(e) Length of stay in Baltimore (yrs., mos., or days) 60 Yrs+

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County None
(c) City or town Baltimore, Md. (If outside city or town limits, write RURAL and give town)
(d) Street No. 2342 Edmondson Ave (If rural give location)
(e) Citizen of foreign country? no (Yes or No) If yes, name country

3 (a) FULL NAME Charles W. Claus

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Katherine M. Claus
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 19, 1867

8. AGE: Years	Months	Days	If less than one day
76	10	20	hr. min.

9. Birthplace York Penna. Md. (Town, county, and state)
10. Usual Occupation Retired
11. Industry or business Bartlett & Hayward

FATHER
12. Name Henry Claus
13. Birthplace Germany

MOTHER
14. Maiden Name Christina Kimball
15. Birthplace Germany

16 (a) Informant Mrs. Robt. E. L. Ernest
(b) Address 3122 Brighton St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 11, 1944 (month) (day) (year)
(c) Cemetery or crematory Loudon Park
Location Balto. Md.

18 (a) Funeral director Robert S. Little
(b) Address 2700 Edmondson Ave.

NOV 10 1944 (b) Huntington Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8, 1944 at 7:50 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 3, 1944 to Nov. 8, 1944, and that I last saw him alive on Nov. 8, 1944

Immediate cause of death Coronary Thrombosis — Duration

Due to

Due to

Other Conditions Bronchopneumonia

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Martin E. Strobel M. D.
Address Maryland Gen'l Hospital Date signed 11/8/44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND RESERVED FOR BINDING

G22431 ✓ G22431

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

186a Registered No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: JOHNS HOPKINS HOSPITAL 27-16
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 40yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3009 Wylie Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Celia Cohen

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex female | 5. Color or race white | 6 (a) Single, married, widowed, or divorced. Widowed

6 (b) Name of husband or wife Late Benjamin

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? - ? - 1882

8. AGE: Years 62 | Months | Days | If less than one day hr. min.

9. Birthplace Russia (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER 12. Name Emanuel Blumberg

13. Birthplace Russia

MOTHER 14. Maiden Name Gertrude ?

15. Birthplace Russia

16 (a) Informant Records JOHNS HOPKINS HOSPITAL

(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov. 10/44 (month) (day) (year)

(c) Cemetery or crematory Hebrew Washington Blvd

Location Washington Blvd

18 (a) Funeral director Adolph Lemmon & Bros

(b) Address 1845-47 W. North ave

19. NOV 10 1944 (b) Huntington Williams, M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1944 at 8:45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 25 1944 to Nov 9 1944 and that I last saw h. alive on Nov 9 1944

Immediate cause of death Fracture neck of femur — Duration 4 days

Due to

Due to

Other Conditions Abdominal Carcinomatosis * M — Duration undetermined

(Include pregnancy within 3 months of death)

Date of operation None

Major findings of operation: none

of autopsy: none

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide accident

(b) Date of occurrence Sept 24 at 2 P. M.

(c) Where did injury occur? Balto Md. (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? home (Specify type of place) While at Work? No

(e) Means of injury Fell down stairs in home

23. Signature Edward J. Bland M. D.

Address Johns Hopkins Hosp Date signed 11-9-44

VS 150 For OH-L. Freeman Co., by Howard J. Morris, M.D.

G22432

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

169

Registered No. G22432

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution South Baltimore Gen. Hosp.
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County A.A.
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No. 604 Belle Grove Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Basil A. Dobbins

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Virginia B. Dobbins

6 (c) If wife, give age years

7. Birth date of deceased (mo., day, yr.) 7/9/895

8. AGE: Years 49 Months 4 Days 1 If less than one day hr. min.

9. Birthplace N. Va. (Town, county, and state)

10. Usual Occupation Conductor

11. Industry or business N. Md. R.R.

FATHER 12. Name Davis Dobbins

13. Birthplace N. Va.

MOTHER 14. Maiden Name Effie Upton

15. Birthplace N. Va.

16 (a) Informant Mrs. Basil Dobbins

(b) Address 604 Belle Grove Rd

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)

(c) Cemetery or crematory Mountain View Park

Location Washington Blvd

18 (a) Funeral director Gahey Funeral Home

(b) Address 847 Light St.

19 (a) NOV 10 1944 (Date rec'd by Registrar) Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 44 19, at 12:45 A. M.

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were

IMMEDIATE CAUSE OF DEATH Crushing & Abdominal Viscera

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-44 at 12:15 A. M. 24-4
(b) Where did injury occur? Cor Covington & Patapsco
(c) Did injury occur at home, on farm, industrial place, in public place? Industrial While at work? Yes
(d) Means of injury Struck by train.

23. Signature N. L. Waldmeier M.D.
Medical Examiner.
Date signed November 9 1944.

G22433

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

186a

Registered No. G22433

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully completed. Physicians: please write the causes of death clearly and legibly. Be sure correct age is especially important.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 1400 N Lexington St
(c) Hospital or institution:
Aged Men's & Women's Home
(d) Length of stay in hospital or inst. (yrs., mos., or days) 12 yrs
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1400 N Lexington St
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Isabella V. Spafford

3 (b) If veteran, name war: W
3 (c) Social Security Account No.: none

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13, 1854

8. AGE: Years 90 | Months 5 | Days 2527 | If less than one day hr. min.

9. Birthplace Balto. Md.
(Town, county, and state)

10. Usual Occupation -none-

11. Industry or business Home for Aged

FATHER
12. Name George A Spafford
13. Birthplace Balto Md

MOTHER
14. Maiden Name Sarah Ann Buck
15. Birthplace Md

16 (a) Informant Mrs. Thompson Aged Men's Home
(b) Address 1400 N Lexington St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/9/44 (month) (day) (year)
(c) Cemetery or crematory Green Mount
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 121 E. Saint Paul St

19 (a) NOV 10 1944 Williams, M.D. Registrar

VS 150

MEDICAL CERTIFICATION A

20. DATE OF DEATH Nov 9 1944 at 1:45 M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/16/1932 19 , to 11/9/44 19 , and that I last saw h er alive on 11/8/44 19 .

Immediate cause of death Myocarditis, chronic — Duration ?

Due to

Due to

Other Conditions Fractured femur

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

8/29/44

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide accident
(b) Date of occurrence Aug. 29/44 at ? M
(c) Where did injury occur? 1400 N. Lexington (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? no
(e) Means of injury Slipped & fell & floor

23. Signature Edwin B Gorrell M. D.
Address 11 E. Chase St., City Date signed 11/9/44

For Attending Physician by Howard J. Madeira, M.D.

G22434

G22434

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 939

Registered No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the correct age is especially important. Write the cause of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 3642 Malden Ave.
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 13 - 8
(e) Length of stay in Baltimore (yrs., mos., or days) Life.

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County .....
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3642 Malden Ave. (If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Kejiah V. Stolock.

3 (b) If veteran, name war — | 3 (c) Social Security Account No. —

4. Sex Female | 5. Color or race White | 6 (a) Single, married, widowed, or divorced widow.

6 (b) Name of husband or wife Francis A. Stolock.
6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) March 6, 1863

8. AGE: Years 81 | Months 8 | Days 3 | If less than one day ..... hr. ..... min.

9. Birthplace Maryland. (Town, county, and state)

10. Usual Occupation Housework.

11. Industry or business

FATHER
12. Name Noah Stockdale.
13. Birthplace Unknown.

MOTHER
14. Maiden Name Martha Algire.
15. Birthplace Unknown.

16 (a) Informant Edith A. Lewis.
(b) Address 3642 Malden Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof NOV 11/44 (month) (day) (year)
(c) Cemetery or crematory Arcadia.
Location: Balto Co, Md.

18 (a) Funeral director Thanner & Donovan
(b) Address 36[illegible] Eutaw Ave

19 (a) [illegible] (b) [illegible]
NOV 10 1944 (Date rec'd by registrar)
Huntington Williams [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1944, at 2 15/60 M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1944 to Nov. 9 1944, and that I last saw h[illegible] alive on Nov. 8. 1944.

Immediate cause of death Congestive Heart Failure — Duration .....
Due to .....
Due to Arteriosclerotic C-V. Disease
Other Conditions
(Include pregnancy within 3 months of death)
Date of operation .....
Major findings of operation: .....
.....
of autopsy: .....

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide .....
(b) Date of occurrence ..... at ..... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury .....

23. Signature Edwin P. Glassman M. D.
Address 4017 Falls Rd. Date signed 11/10/44

VS 150

G22435 Subject to approval by Medical Examiner: X ✓ G22435

BALTIMORE CITY HEALTH DEPARTMENT

JO #90584

CERTIFICATE OF DEATH 1944

Registered No.

PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution:
Baltimore City Hospitals
(d) Length of stay in hospital or inst. (yrs., mos., or days) 20 min.
(e) Length of stay in Baltimore (yrs., mos., or days) ?

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Baltimore County
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1006 Elton Terrace
(If rural give location)
(e) Citizen of foreign country? Yes or No
If yes, name country

3 (a) FULL NAME
Shirley Young

3 (b) If veteran, name war
3 (c) Social Security Account No.

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) ? ? ?

8. AGE: Years 1 | Months 6 ? | Days ? | If less than one day hr. min.

9. Birthplace ? Balto. Md.
(Town, county, and state)

10. Usual Occupation Unable to obtain further
11. Industry or business information.

FATHER
12. Name Eugene
13. Birthplace ?

MOTHER
14. Maiden Name Catherine ?
15. Birthplace ?

16 (a) Informant Records, Baltimore City Hosp.
(b) Address 4940 Eastern Avenue

17 (a) (Burial, cremation, or removal) (b) Date thereof April 13 1944 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location

18 (a) Funeral director Sawalin Funeral Home
(b) Address 7401 Belair Rd

19 NOV 10 1944 (b) Huntington Williams M.D.
(Date received by Local Registrar) (Signature of Local Registrar)

VS 150 SUBJECT TO REMOVAL Baltimore, Md. Thomas J. Mullaney M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1944 at 3:00 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 11-9 1944 to 11-9 1944, and that I last saw her alive on 11-9 1944.

Immediate cause of death: Asphyxia — Duration

Due to Aspiration of Peanut

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation Laryngoscopic [illegible] attempted removal

Major findings of operation showed peanut caught in vocal cords

of autopsy causing complete obstruction & asphyxia

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature P.R. Cullen M. D.
Address Balt City Hosp Date signed 11-10-44

PHYSICIAN
Underline the [illegible] shoulder charged statistically

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

G22436

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 940

G22436

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: Mercy Hospital 12
(d) Length of stay in hospital or inst. (yrs., mos., or days) D.O.A.
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2936 ST. Paul ST.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME James Hodges Ridgely

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W.	Married

6 (b) Name of husband or wife: Jane Hanzsche

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 13, 1888

8. AGE: Years	Months	Days	If less than one day
56	7	28	hr. min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual Occupation: Insurance

11. Industry or business

FATHER
12. Name: Joseph Graham Ridgely
13. Birthplace: Md.

MOTHER
14. Maiden Name: Mary Hodges Fisher
15. Birthplace: Md.

16 (a) Informant: Mrs. Jane Hanzsche Ridgely
(b) Address: 2936 St. Paul St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)
(c) Cemetery or crematory: Woodlawn Cem.
Location: Woodlawn, Md.

18 (a) Funeral director: WM. J. TICKNER & SONS
(b) Address: Balto., Md.

NOV 10 1944 (Date rec'd by registrar)
(b) Hunter Sr. Williams, M.D. Registrar

VS 161

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9 1944, at 6 30 P M

21. I certify that I took charge of the remains described above, held an Inspection (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑ accident ☐ suicide ☐ homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Occlusion

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert L. Gaston M.D.
Medical Examiner.
Date signed Nov. 10 1944

C22437

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 171a

Registered No. C22437

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Baltimore Maryland
(c) Hospital or institution Union Memorial Hospital 9
(d) Length of stay in hospital or inst. (yrs., mos., or days) d.o.a.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 706 E. 41st St.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Lena M. Marshall

3 (b) If veteran, name war: none

3 (c) Social Security Account No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 25, 1880

8. AGE: Years	Months	Days	If less than one day
64	7	14	hr. min.

9. Birthplace Staunton, Va.
(Town, county, and state)

10. Usual Occupation Mgr. Dress Shop

11. Industry or business Virginia Lee

FATHER
12. Name Wm. H. Marshall
13. Birthplace Va.

MOTHER
14. Maiden Name Mary E. Montgomery
15. Birthplace Va.

16 (a) Informant Mrs. Robert E. Lee Russell
(b) Address 706 E. 41st St. 18

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 11/10/44 (month) (day) (year)
(c) Cemetery or crematory Thornrose Cem.
Location Staunton, Va.

18 (a) Funeral director WM. J. TICKNER & SONS
(b) Address Balto., Md.

19 (a) NOV 10 1944 (Date received by Registrar) (b) Huntington Williams, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 9, 1944, at 9:28 A. M.

21. I certify that I took charge of the remains described above, held an autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:
(Autopsy, Inspection or Inquiry)

IMMEDIATE CAUSE OF DEATH
Fracture of skull

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 11-9-44 at 9:13 A. M.
(b) Where did injury occur? Greenmount Ave & Rosehill Terrace
(c) Did injury occur at home, on farm, industrial place, in public place? Public. While at work? No.
(d) Means of injury Pedestrian struck by streetcar.

23. Signature H. Z. Wollenweber M.D.
Medical Examiner.
Date signed November 9, 1944.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS 151

G22438

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

83a

Registered No. G22138

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. Underline the cause to which death should be charged statistically. Be sure that age is especially important.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 4205 Penhurst Ave.

(c) Hospital or institution:

2871

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Balto. (If outside city or town limits, write RURAL and give town)

(d) Street No. 4205 Penhurst Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3 (a) **FULL NAME** ELIA BREWER

3 (b) If veteran, name war: none

3 (c) Social Security Account No. none

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Widow

6 (b) Name of husband or wife Ernest E.

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 7, 1861

8. AGE: Years	Months	Days	If less than one day
83	10	2	hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER

12. Name James Lawrence McPhail

13. Birthplace Balto., Md.

MOTHER

14. Maiden Name Margaret A. Harman

15. Birthplace Balto., Md.

16 (a) Informant MR. William B. Brewer

(b) Address 4205 Penhurst Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 11/11/44 (month) (day) (year)

(c) Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

NOV 10 1944 (Date rec'd by registrar) Huntington Williams M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9, 1944, at 7:30AM

21. I certify that I attended the above-named deceased from Oct. 17 1944 to Nov. 9 1944 and that I last saw h alive on Nov. 9 1944

Immediate cause of death: Cerebral Apoplexy — Duration 3 wks.

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature Henry E. Nolan

Address 3 E. Biddle Date signed 11-9-44 M.D.

VS 150

G22439

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 83a

Registered No. G22439

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address 2314 Mayfield Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 8 1
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2314 Mayfield Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward A Hammann

3 (b) If veteran, name war | 3 (c) Social Security Account No.

4. Sex: male | 5. Color or race: white | 6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife Elizabeth Hammann
6 (c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) Mar 2 1887

8. AGE: Years 57 | Months 8 | Days 5 | If less than one day ... hr. ... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual Occupation Internal Rev Dept
11. Industry or business

FATHER
12. Name Jacob Hammann
13. Birthplace Balto

MOTHER
14. Maiden Name Elizabeth Jersheid
15. Birthplace Balto

16 (a) Informant Elizabeth Hammann
(b) Address 2314 Mayfield Ave

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Nov 10 44 (month) (day) (year)
(c) Cemetery or crematory Oak Lawn
Location Balto Co Md

18 (a) Funeral director Ullrich Fumeral Home
(b) Address 2008 Orleans St

18 (c) NOV 10 1944 (Date received by Registrar) Huntington Williams MD (Registrar)

VS 150

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7- 1944 at 3 43 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 11-4 1944, to 11-7- 1944 and that I last saw h.j.m alive on 11-7- 1944

Immediate cause of death: Cerebral Apoplexy with Left Hemiplegia — Duration: 4 days
Due to: Arteriosclerosis — 7 years
Due to:
Other Conditions:

(Include pregnancy within 3 months of death)
Date of operation:
Major findings of operation:
of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature Milton C. Carey M. D.
Address 2117 Belair Rd Date signed 11-9-44

G22440

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 1170

G22440

MARYLAND RESERVED FOR READING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied, correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address
(c) Hospital or institution: St Joseph's Hospital 27
(d) Length of stay in hospital or inst. (yrs., mos., or days) 14 days.
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 802 Radnor Ave.
(If rural give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3 (a) FULL NAME James C. Roberts

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-8266

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Mildred E.
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 5-1-92.

8. AGE: Years	Months	Days	If less than one day
52	6	6	hr. min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual Occupation Clerk.
11. Industry or business Beth. Steel Co.

FATHER
12. Name James C. Roberts
13. Birthplace Balto

MOTHER
14. Maiden Name Hester Long
15. Birthplace Baltimore

16 (a) Informant Mrs Mildred Roberts
(b) Address 802 Radnor Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 10 - (month) (day) (year)
(c) Cemetery or crematory Lorraine Park
Location Woodlawn

18 (a) Funeral director Wells & Funeral Home
(b) Address 2904 E. Orleans St.

NOV 10 1944 (Date rec'd by registrar) Huntington Williams M.D.

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7 1944 at 7:25 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10-24 1944 to 11-7 1944, and that I last saw him alive on 11-7 1944.

Immediate cause of death Cardio-respiratory Failure

Due to Cardiac decompensation

Due to Atelectasis + Pneumonia

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation 10-30-44

Major findings of operation: Gastric Ulcer.

of autopsy: Perforation of Bowel.

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Melvin D. Jamonds M. D.

Address ST Joseph's Hospital Date signed 11-7-44

VS 150

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 8/1 DAY OF 1963 THE MICROPHOTOGRAPHS APPEARING HEREIN STARTING WITH 19356 AND ENDING WITH 22440 ARE ACCURATE AND COMPLETE REPRODUCTIONS OF THE RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics AS DELIVERED IN THE REGULAR COURSE OF BUSINESS FOR PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC COPY.

CAMERA OPERATOR: Loretta Byrne

END OF REEL